SOAH DOCKET NO. 453-05-1230.M5
TWCC MR NO. M5-04-1183-01

HARTFORD CASUALTY INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
SYZYGY ASSOCIATES, L.P.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**
	§	

DECISION AND ORDER

This is a dispute over reimbursement for services performed for an injury suffered by Claimant while in the course and scope of his employment. The Administrative Law Judge (ALJ) concludes that the work hardening services should be not be reimbursed, since the services provided by Respondent, Syzygy Associates, L.P., were not medically necessary or adequately documented.

I. FACTUAL AND PROCEDURAL HISTORY

Claimant suffered a work-related injury to his lower back on___. The Claimant visited Troy Van Biezen, D.C. on ___, and the doctor treated him until July 10, 2003. On July 10, 2003, Dr. Van Biezen determined that the Claimant had achieved the maximum therapeutic benefit possible and referred him for work hardening.[1] On July 18, 2003, Robert E. West, OTR, performed a functional capacity evaluation (FCE) and recommended four to six weeks of work hardening. Mr. West, an employee of Syzygy Associates, L.P. (Provider), provided work hardening to Claimant from July 21, 2003, through August 22, 2003.

Claiming lack of medical necessity and inadequate documentation, the Carrier denied reimbursement of Provider's treatment of Claimant for services rendered from July 21, 2003, through August 22, 2005. The Carrier denied certain services in the date range August 11 through August 15, 2003, under the V code (medical necessity with peer review) in its Explanation of Benefits forms (EOBs). The remainder of the work hardening services were denied for inadequate

[1] Carrier's Ex. 1 at 11-12.

documentation, using the N code.

The Provider filed a timely request for medical dispute resolution (MDR # M5-04-1183-01). The Independent Review Organization (IRO) determined that services disputed under the V code were not medically necessary.[2] The Medical Review Division, however, determined that the remainder of the services were adequately documented, and the Carrier appealed (Disputed Services). The Disputed Services were rendered under CPT codes 97545, 97546 and 97750. The amount in dispute in $9,216.00.

Carrier filed a timely request for hearing before the State Office of Administrative Hearings (SOAH) on October 4, 2004. The Texas Worker's Compensation Commission (TWCC) served its notice of hearing in this matter on November 8, 2004. A hearing was held on November 30, 2005, before ALJ Travis Vickery. Provider and Carrier participated in the hearing, which was adjourned the same day. The record closed on December 23, 2005.

II. ANALYSIS

A. Provider's Notice of Medical Necessity as a Reason for Denial

At the hearing, the Carrier argued that the Disputed Services were not medically necessary. Provider, however, pointed out that the EOBs upon which the Carrier bases its appeal were all coded N B a challenge to Provider's documentation, not medical necessity. The records in this matter reflect that the Disputed Services were never reviewed by an IRO for medical necessity, but rather by the MRD for documentation. Although Carrier's denial code is for inadequate documentation, this matter is coded as an M5, a dispute over medical necessity. Normally, the ALJ would analyze this as a fee dispute, because the Carrier failed to challenge the Disputed Services with the denial code for medical necessity. But in this matter, it appears that even if it is regarded as a fee dispute, the Provider failed to meet the requirements of the medical fee guidelines In addition, limiting this reviewto a review of records could undermine the purpose of the Worker's Compensation Act and ignore the reason that such denial codes exist - notice to the Provider of Carrier's grounds for denial.

[2] The Provider did not appeal this finding.

The rules require a carrier to respond to a medical bill within 45 days of its receipt.[3] If the carrier denies part of the bill, the rules also require it to provide a denial code and rationale on an EOB within the 45 days, so that the Provider understands the reason for the denial:

> At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits *shall include the correct payment exception codes* required by the Commission's instructions, and *shall* provide sufficient explanation *to allow the sender to understand the reason(s) for the insurance carrier's action(s)* . . . [Emphasis added].[4]

The time limit and the mandatory language of 28 TAC § 133.304(c) makes clear a carrier has a duty to provide a denial code and understandable reasons for denial within 45 days.

Undoubtedly, the Carrier here failed to deny payment for the Disputed Services with the denial code for medical necessity. Normally such a failure raises issues of the Provider's notice of the Carrier's grounds for denial. Yet, as early as October, 2003, the Provider acknowledged its understanding that the Carrier denied the entire period of work hardening as medically unnecessary and lacking adequate documentation.

The 24 days of work hardening occurred in a discrete period from July 21 through August 22, 2003. On September 4, 2003, the Carrier received a peer review recommending denial of reimbursement for the work hardening. On October 6, 2003, the Carrier transmitted it to the Provider. The cover letter stated:

> Please find attached a copy of a pm&r-w/h peer review on services rendered on the above-referenced injured worker. Based on the peer review findings and in the absence of information to the contrary, reimbursement will be based on the results of this review.

---

[3] 28 TEX. ADMIN. CODE (TAC) § 133.304(a).

[4] 28 TAC§ 133.304(c).

The peer review clearly recommended denial for medical necessity and lack of documentation:

> 1. Is a lengthy and complicated Work Hardening Program reasonable and necessary for this injured worker? Yes or No. Please explain.
>
> No. The patient does not meet the needs of a work hardening program. *The patient does not have a psychological evaluation, and there does not seem to be a psychological component that is thoroughly documented for this patient* at this point in time. Also, the patient basically seemed to have more chiropractic treatment as opposed to active exercise based physical therapy program.
>
> 2. Do the treatment history and psychiatric notes indicate a need for an interdisciplinary approach? Yes or No. Please explain.
>
> No. There is just one behavioral note provided. *There is not a full-blown evaluation from either a licensed pain psychologist or a psychiatrist to see if there is a significant psychological component to this patient's pain.* The date of injury is from 4/16/03. It would seem this patient would not need to have a whole interdisciplinary work hardening program done. This patient has had plenty of rehabilitation and could just benefit from some active exercise program and transition to a home exercise program. The patient may possibly be eligible for work conditioning. [Emphasis added].[5]

The peer review also recommended work conditioning, lamented the lack of adequate documentation and reiterated that there is no evidence of an interdisciplinary program with a psychological component. Most important, the Provider could hardly claim surprise at the hearing on the merits, because the Carrier's arguments mirrored exactly the peer review's reasons for denial.

On October 30, 2003, the Provider responded to the peer review in a request for reconsideration. The response reveals that the Provider clearly understood that Carrier's denial was based on medical necessity and lack of records:

> Regarding denial of payment for work hardening . . . Based on the FCE results, there is more than sufficient "Medical Necessity" for [Claimant] to enter a work hardening program . . .
>
> Upon review of the provided insurance documentation and peer review, it was stated that "The patient does not meet the needs for a work hardening program" "does not have a psychological evaluation" to back a psychological component . . .

[5] Provider's Ex. 1 at 1-03.

> Mockingbird Workskills has clear and full documentation supporting "medical necessity"for [Claimant's] work hardening program . . . [Emphasis in original].[6]

The Provider's response echoes the peer review's grounds for denial and the Carrier's argument at the hearing on the merits. In addition, the Provider's December 22, 2003 request for dispute resolution alleges that work hardening was medically necessary,[7] and the TWCC 60 form requests an IRO for a review of "Retrospective Medical Necessity."[8] There is no doubt that the Provider had notice of Carrier's denial of the entire work hardening treatment program as both medically unnecessary and inadequately documented.

The fact that both parties were focused on medical necessity and documentation reflects the discrete and heterogenous nature of the work hardening services rendered in this case. All five weeks of work hardening involved the same two CPT Codes, 97545 and 97546. There is no rational basis for analyzing only one week of five for medical necessity when they were all the same. In its post-hearing brief, the Carrier suggested that it used denial codes N and V because the issues of medical necessity and documentation were so closely related. That is, it was unclear whether documents reflecting medical necessity were missing, or simply never existed. The peer review and Provider's response cited above, reveal that both parties saw it this way.

Under the rule stated in 28 TAC § 133.304(c), carriers are required to deny services with an appropriate denial code and rationale. Although the Carrier failed to state the proper denial code, it did transmit the peer review explaining the Carrier's reason for denial. As a result, it appears that TEX. LAB. CODE §408.027(d) was satisfied:

> If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission, the health care provider, and the injured employee *a report that sufficiently explains the reasons for the reduction or denial of payment for health care services* provided to

[6] Provider's Ex. 1 at 2-04.

[7] Provider's Ex. 1-01.

[8] Provider's Ex. 1-02.

the employee . . . [Emphasis added].[9]

The purpose of 28 TAC § 133.304(c) and TEX. LAB. CODE § 408.027(d) is to give a provider notice of the carrier's reason for its actions B the first step in the due process to which every provider is entitled. But when, through some flaw, the denial code is inconsistent with an otherwise clearly stated and understood reason for denial, the purpose of the rule has nevertheless been satisfied. Furthermore, if the communicated reason for denial possesses merit, strict adherence to the rule has the potential to undermine the intent of the Act. When that potential is realized, the rule disturbs the Act for no good purpose.

As discussed below, the ALJ finds that the documents establish work hardening was medically unnecessary. To analyze this matter strictly as a fee dispute would require the ALJ to review and ignore the very documents that prove work hardening was medically unnecessary. The ALJ declines to conduct a document review with blinders on when the Provider had incontrovertible notice that the Carrier intended to challenge the medical necessity of the Disputed Services, and to do otherwise would subvert the intent of the Act. The ALJ analyzes this matter as one of medical necessity and documentation

B. Work Hardening and Documentation

None of the work hardening or work hardening-related services or testing were medically necessary. Furthermore, amongst other documentation shortfalls, there is no record of a treatment plan as required under the 1996 Medical Fee Guidelines for work hardening. Since the issues of documentation and medical necessity are related, they will be discussed together and later distinguished in the findings of fact and conclusions of law.

[9]TEX. LAB. CODE§ 408.027(d).

Work hardening began on July 21, 2003, and extended through August 22, 2003. During that period, the Provider billed services under CPT Codes 97545, 97546 and one unit of 97750. The Carrier's Exhibit 1 was represented to be the complete, chronological medical records for this claim.[10] On July 10, 2003, treating doctor, Dr. Troy VanBiezen recommended work hardening for the Claimant.[11] On July 18, 2003, the Claimant received a Functional Capacity Evaluation (FCE) from Robert West, OTR. Based on the FCE, Mr. West recommended and performed work hardening on the Claimant. Although the Carrier contends that the work hardening should not have been performed in the absence of an authorization by Dr. VanBiezen, the ALJ disregards this argument in light of the doctor's clear desire for the Claimant to pursue work hardening.

A more significant issue is the lack of a psychological evaluation of the Claimant for fitness for the program. The Carrier asserts that the 1996 Texas Worker's Compensation Commission Medical Fee Guideline, Medicine Ground Rules apply here (Medicine Ground Rules). Although the Provider did not address this assertion, the ALJ agrees with the Carrier. The Medicine Ground Rules describe work hardening as:

> A highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. Work hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker . . . [w]ork hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks . . .[12]

In a cover letter to the July 18, 2003, FCE, Mr. West stated that the Claimant". . . reports significant mental distress from his current injury and remaining off work."[13] Although the Claimant needed the mandatory psychological component of work hardening, no psychological evaluation was performed before he began treatment, nor was a treatment plan drafted to address his needs. The Medicine Ground Rules state a practical entrance criteria for work hardening: the patient

---

[10] See Carrier's Brief at 11.

[11] Carrier's Ex.1 at 11, 12.

[12] 1996 Texas Worker's Compensation Commission Medical Fee Guideline, Medicine Ground Rules I. E p. 37.

[13] Carrier's Ex. 1 at 14.

must be likely to benefit from the treatment and be free of any psychological condition that would interfere with participation.[14]

Instead of addressing the obvious issue of Claimant's suitability for work hardening, the Provider simply proceeded with treatment. On July 22, 2003, two days after treatment began, the Claimant received a psychological screening entitled "Rehabilitation Symptom Pre-Screen Scoring Summary" (Pre-Screen)[15] The name of the document alone suggests that it should have taken place prior to treatment. Furthermore, the disclaimer states: "The results . . . are not a substitute for a clinical interview or a formal psychological evaluation, and cannot render a mental health diagnosis." The Pre-Screen recommended a psychological assessment of the Claimant concurrent with treatment.

Remarkably, a psychological assessment was not performed until three days prior to the end of the treatment, on August 19, 2003.[16] The assessment stated that the Claimant was not likely to benefit from treatment until his psychological condition was addressed:

> Without significant changes in their beliefs, this would constitute an extremely poor prognostic sign for recovery of function. Scores in this range are usually associated with poor outcomes from traditional medical/surgical interventions, and suggest the possibility of psychological factors contributing to a continuing disability without essential changes in this mind set.

The recommendation was:

> These problems are likely to hinder his rehabilitation process unless they are addressed. At present, the patient is in need of psychological services to facilitate adequate development of coping skills to manage his emotions and pain in relation to his chronic pain syndrome. Since being treated for his injuries, he has not returned to his previous level of functioning, nor has he responded well to such interventions or the process of rehabilitation as would be expected.

Had this assessment been performed prior to work hardening as it should have been, work hardening should not have begun until after the Claimant was likely to benefit from the treatment and be free of

[14] 28 TAC § 134.201.

[15] Carrier's Ex. 1 at 44.

[16] Carrier's Ex. 1 at 97-100.

any psychological condition that would interfere with participation, as required in the Medicine Ground Rules. As a measure of the efficacy of work hardening for the Claimant, he failed to return to work after the treatment ended on August 22, 2003, and instead engaged in individual counseling.[17] Dr. William Defoyd, D.C. testified on behalf of the Carrier. Dr. Defoyd opined that taking the Claimant as he was in July 2003, he was not likely to benefit from work hardening. The ALJ agrees and finds that work hardening was medically unnecessary.

Perhaps the Provider's failure to clear the Claimant for work hardening is related to its failure to draft a treatment plan as required. Although the Carrier complains about the lack of a number of records for this Claimant, the ALJ sees the lack of a treatment plan as seminal and inclusive of other documentary shortfalls. Had the Provider developed an interdisciplinary treatment plan prior to treatment, it would have taken a much better look at the Claimant's psychological condition. Regarding the Claimant's physical condition, an FCE was performed and there are daily treatment notes reflecting patient response B satisfying that requirement. Yet, the Medicine Ground Rules clearly require a written treatment plan:

> 7. Program supervision is provided by a licensed physical or occupational therapist or by a doctor. The program supervisor *shall*:
>
> 3. *write the treatment plan* for the patient and write changes to the plan based on documented changes in the patient's condition;[18] (Emphasis added.)

Based on the definition of work hardening, it is fatal to Provider's recovery that there exists no evidence of the mandatory treatment plan, no reasoned justification for work hardening, no interdisciplinary approach, and no mandatory psychological component.[19] The Provider will not be reimbursed for the Disputed Services billed under CPT Codes 97545, 97546 and 97750. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

---

[17] Carrier's Ex. 1 at 111, 113, 115 and 116.

[18] 1996 Texas Worker Compensation Commission Medical Fee Guideline, Medicine Ground Rules II. E

[19] 1996 Texas Worker's Compensation Commission Medical Fee Guideline, Medicine Ground Rules II. E p. 38.

III. FINDINGS OF FACT

1. Claimant ___suffered compensable, work-related injuries to his lower back on___.

2. Hartford Casualty Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.

3. On July 18, 2003, Claimant visited Syzygy Associates, L.P. (Provider) and received work hardening treatment from July 21 through August 22, 2003.

4. Carrier declined to reimburse Provider's treatments, denying one week of services (August 11 through August 15, 2003) under the V denial code as not medically necessary and denying the remainder of the services as inadequately documented under the N denial code.

5. Based on the Consolidated Table of Disputed Services, the total amount in dispute is $9, 216.00. The disputed services involve work hardening (CPT Codes 97545 and 97546) and one unit of testing (CPT Code 97750).

6. Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission).

7. There were two dispute resolution reviews. The services denied as medically unnecessary was referred to an IRO designated by the Commission for the review process, while MRD reviewed the remainder of work hardening for documentation.

8. The IRO determined that the work hardening from August 11 through August 15, 2003, was not medically necessary.

9. The Medical Review Division (MRD) reviewed work hardening and agreed with the Provider recommending reimbursement to the Provider for all work hardening treatments from July 21 through August 22, 2003, except the week of August 11 through August 15, 2003.

10. On October 4, 2004, the Carrier requested a hearing before the State Office of Administrative Hearings (SOAH).

11. The Texas Worker's Compensation Commission served its notice of hearing in this matter on November 8, 2004.

12. The hearing convened on November 30, 2005, with ALJ Travis Vickery presiding. Provider appeared telephonically. Carrier appeared through its counsel. The hearing concluded and the record closed on December 23, 2005.

13. No parties objected to notice or jurisdiction.

14. Claimant was not psychologically able to benefit from work hardening at the time it began on July 21, 2003.

15. No work hardening treatments billed under CPT Codes 97545 and 97546 were medically necessary for Claimant.

16. The Functional Capacity Evaluation billed on August 14, 2003, under CPT Code 97750 was not medically necessary because the work hardening treatments were not medically necessary.

17. Provider failed to adequately document work hardening treatments for Claimant.

IV. 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 work hardening treatments and Functional Capacity Evaluation provided to Claimant and billed under CPT Codes 97750, 97545 and 97546 were not reimbursable because they were not medically necessary for treatment of Claimant's compensable injury.

7. Carrier has shown, by a preponderance of the evidence, that the services provided to Claimant and billed under CPT Codes 97545 and 97546 were not adequately documented and are not reimbursable.

ORDER

Hartford Casualty Insurance Company need not reimburse Syzygy Associates, LP for services provided under CPT Codes 97545, 97546 or 97750 for dates July 21 through August 22, 2003 for Claimant.

SIGNED February 17, 2006.

_____

TRAVIS VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS