SOAH DOCKET NO. 453-05-6619.M5
TWCC MR NO. M5-05-1751-01

CONTINENTAL WESTERN INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
V.	§	**OF**
	§	
BEXAR COUNTY HEALTHCARE SYSTEMS,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Continental Western Insurance Company (Carrier) appealed a Texas Workers' Compensation Commission (Commission)[1] Medical Review Division (MRD) decision, issued on the basis of medical necessity, that ordered payment for a chronic pain management (CPM) program provided to an injured worker (Claimant) by Bexar County Healthcare Systems (Provider) from November 29, 2004, through December 23, 2004. For matters within the jurisdiction of the State Office of Administrative Hearings (SOAH), this decision upholds MRD's determination. However, not all disputed matters are within SOAH's jurisdiction. Carrier submitted a TWCC PLN11 filing to the Commission on January 12, 2005, asserting an "extent of injury" dispute, in which it contended Claimant was being treated for anxiety and depression that were unrelated to his injury. The Administrative Law Judge (ALJ) concludes that SOAH lacks jurisdiction to determine the matters asserted in Carrier's TWCC PLN11 filing. The ALJ will order that Carrier's appeal of MRD's decision be denied, but that final action is abated pending the Division's decision on the PLN11 filing.

The hearing convened on March 7, 2006, at the SOAH offices in the William P. Clements Building, 300 West 15th Street, Austin, Texas, before the undersigned ALJ. Carrier was represented by its counsel, Steven Tipton. Provider was represented by its workers' compensation insurance

[1] Effective September 1, 2005, the functions of the Commission were transferred to the newly created Division of Workers' Compensation of the Texas Department of Insurance (Division).

coordinator, Arturo Gonzales. The hearing record closed on March 8, 2006, with the submission of additional documentation.

II. ANALYSIS

A. Medical Necessity-Legitimacy of CPM Provided

Carrier acknowledged that it pre-authorized the 20 hours of CPM in dispute and that under ordinary circumstances it is precluded from challenging the medical necessity of a pre-authorized service. It maintained, however, that contesting a service is permissible if it is not the one actually preauthorized[2] or if the insurer was mislead when it preauthorized the service.

Carrier witness Krista Jordan, Ph.D.,[3] testified that Provider's CPM program did not meet generally accepted standards for CPM programs in several respects, including:

- Provider did not provide services for eight hours per day as promised. The sessions ranged from 3.40 hours to 8.30 hours in length, with only two of the nineteen sessions equaling or exceeding eight hours. Almost half of the sessions were less than six hours and four were less five hours.

[2] On Carrier's request, the ALJ took official notice of a Commission comment in the adoption preamble for 28 TEX. ADMIN. CODE §134.600, a rule that provides standards and procedures for preauthorized services. The Commission stated, "However, Carrier will retrospectively review the treatment rendered to determine that the health care provided corresponds to the requested and approved health care plan." 26 TexReg 9892.

[3] Dr. Jordan's doctorate is in psychology. Her studies have included research into CPM, with particular focus on patients with low-back pain. She has been program director for a CPM program.

- Claimant's depression and anxiety scores actually worsened and Claimant's pain scores did not improve during the program. Dr. Jordan said Provider should have realized Claimant was not benefitting from the program. She maintained Provider gave Claimant pain medication rather than teaching him to manage his pain.

- Claimant's sleep disorder was inadequately treated.

- Claimant's biofeedback was improperly done.

- Claimant did not receive individual psychotherapy on a daily basis.

- Claimant received little or no work simulation. Activities that were provided, such as going to the movies or walking in a mall, did not relate to his job as a landscaper.

- Vocational training was minimal, with no meaningful vocational counseling services.

- Claimant received nutritional counseling, but that has not been validated as effective for a CPM program.

Dr. Jordan testified and Carrier asserted that, overall, Provider's CPM program did not meet Commission on Accreditation of Rehabilitation Facilities standards as required by the Division's rules at 28 TEX. ADMIN. CODE §134.202.

The ALJ concludes the record does not support Carrier. Pursuant to TEX. LAB. CODE ANN. 413.014(e)[4] and 28 TEX. ADMIN. CODE (TAC) §133.301(a),[5] Carrier's preauthorization of a CPM program [6] precludes it from challenging the medical necessity of services that have been provided.

As indicated above, Carrier argued that even when it is precluded from retrospectively challenging medical necessity, it may review the program to determine whether the services that were preauthorized were actually provided. According to Carrier, because the CPM program did not meet the necessary standards, it failed to provide the health care that was preauthorized.

[4] This section provides, "[i]f a specified health care treatment or service is preauthorized . . . that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service."

[5] This rule states, "[t]he insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments)."

[6] Ex. 2 at 8-9.

The ALJ agrees that an insurance carrier is permitted to challenge a preauthorized service on the ground that the service provided was not the one preauthorized.[7] However, in doing so, it is required to comply with §408.027 of the Labor Code and 28 TAC §133.304(c). Section 408.027(e) says an insurance carrier that disputes the amount of payment or the health care provider's entitlement to payment shall send to MRD, the provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment. Section 133.304(c) states that an EOB shall contain the appropriate denial code and sufficient explanation to allow the sender to understand the reason for the insurance carrier's actions. Carrier did not claim, either on its EOBs or in its response to Provider's request for MRD action, that the CPM was not the one authorized. Based on the exhibits admitted, it appears that Carrier raised for the first time at the hearing the issue of whether the service provided was the one preauthorized.

Moreover, there was insufficient evidence to conclude that Carrier was induced by a Provider misrepresentation to preauthorize the CPM, *i. e.*, that Carrier relied on a material and knowingly false or reckless misrepresentation in approving the services. In any case, Carrier did not assert this ground for denial in its EOB or otherwise before medical dispute resolution.

For these reasons, the ALJ concludes that Carrier's appeal on the grounds addressed in this Part II.A. should be denied.

B. Extent of Injury

As indicated in the first paragraph of this decision, the ALJ concludes that SOAH does not have jurisdiction to consider the extent-of-injury issue raised in Carrier's PLN11 submission to the Division, asserting that Claimant was treated for anxiety and depression that were unrelated to the Claimant's at-work injury. Carrier's submission was filed under TEX. LAB. CODE ANN. ch. 410.

[7] This is not a statement that an insurance carrier is permitted to contest preauthorized services based on any assertion it might make that the services provided were in some way inadequate. The ALJ is not convinced, one way or the other, that the above-quoted sentence in footnote 2 from the Rule 134.600 adoption preamble, that carriers are permitted to review the treatment provided to see whether it is the one preauthorized, refers to situations other than where the service provided is entirely different than the one preauthorized.

Chapter 410 prescribes an extensive process for an internal Division determination of an insurance carrier's liability for an injury or for services that may or may not be related to a particular injury.

The parties urged the ALJ to decide the extent-of-injury issue in view of statutory law changes that went into effect on September 1, 2005, making it unlikely that the case will ever receive a SOAH determination on this matter if it is remanded to the Commission. The ALJ believes, however, that any possible avenue for making that decision is foreclosed by the PLN11 filing, which placed the extent-of-injury issue squarely before the Commission in January 2005.

C. Anxiety and Depression

As indicated above, the ALJ concludes that anxiety and depression are addressed in Carrier's PLN11 filing and therefore are not within SOAH's jurisdiction. However, to the extent either party has argued the anxiety and depression issue requires a medical necessity rather than extent-of-injury decision or that it is within the ambit of the matters discussed in Part I.A. (the treatment provided was not the one preauthorized or Carrier was improperly induced into preauthorizing the service), the ALJ believes it is appropriate to consider Carrier's assertions in order to address all possible issues before SOAH. The ALJ concludes Carrier's appeal should be denied on the same grounds as stated in Part I.A. B that the services were preauthorized as medically necessary and Carrier failed to adequately state on a timely basis any other ground for denying Provider's request.

Carrier contended it informed Provider of its position in its EOB for these services[8] when it said "unnecessary medical per RME 11-04-04." A November 4, 2004, Required Medical Examination by Wayne H. Gordon, M.D., contains an addendum saying Claimant's current depression and anxiety are not related to the work-related injury and that requested pain management or psychological studies are not reasonable and necessary in relation to the injury.

The ALJ finds this argument unpersuasive because Dr. Gordon's opinion provided before the addendum was that Claimant did not require future medical treatment except for pain medications, non-steroidal anti-inflammatories, muscle relaxants, and a home exercise program. This opinion

[8] Ex. 2 at 28-29.

was clearly medical-necessity based, whereas the addendum appears to be relatedness based. Carrier's EOB used the "U" code and the Carrier's own 244 code for unnecessary medical service.[9] It was reasonable to conclude that the EOB reference to Dr. Gordon's opinion was to his opinion on the necessity of future treatments rather than his opinion on depression and anxiety, which he identified as relatedness issues. In any case, Carrier did not adequately comply with the §133.304(c) standards requiring both a clearly understandable statement of its position and the use of a correct denial code, *i.e.*, "R" or "229," if it wanted to assert an extent-of-injury dispute.

Carrier also argued it provided notice of its position in a subsequent pre-authorization for additional CPM that said "Carrier disputing depression and anxiety,"[10] a subsequent EOB that clearly identified the relatedness issue,[11] and the January 2005 PLN11 form, which raised the issue before the matter was referred to medical dispute resolution in February 2005. These assertions were unpersuasive. The subsequent pre-authorization related to later, different services in January 2005; the subsequent EOB was not issued until after MRD reached its decision; and the PLN11 was not delivered to Provider. Moreover, none of these statements satisfied the above-described notice requirements of §133.304(c), that an understandable explanation of the insurance carrier's position and a correct denial code be delivered with the EOB that denied payment for the service at issue.

III. FINDINGS OF FACT

1. On April 22, 2005, the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) ordered Continental Western Insurance Company (Carrier) to pay for chronic pain management (CPM) services provided by Bexar County Healthcare Systems (Provider) to an injured worker (Claimant) from November 29, 2004, thorough December 23, 2004.

2. It is undisputed that Carrier requested a hearing before the State Office of Administrative Hearings (SOAH) not later than the 20th day after receiving notice of the MRD decision.

3. Notice of the hearing was sent to both parties and contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the

[9] Denial code R is used for extent-of-injury disputes. Carrier's own extent-of-injury denial code appears to be "229." Ex. 1 at 16.

[10] Ex. 1 at 5.

[11] Ex. 2 at 15-16.

hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

4. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

5. Carrier preauthorized the CPM program referred to in Finding of Fact No. 1.

6. The Explanation of Benefits (EOB) denying the CPM services said the claim was denied based on "unnecessary medical" and "unnecessary medical per RME 11-04-04."

7. Carrier did not claim, on either an EOB provided before Provider's request for medical dispute resolution or in its response to Provider's request for MRD action, that Provider's services were not the ones preauthorized or that it had been induced to preauthorize the CPM by Provider's misrepresentation.

8. In a November 4, 2004 Required Medical Examination (RME), the doctor issued a medical-necessity determination that further services were not necessary except for pain medications, non-steroidal anti-inflammatories, muscle relaxants, and a home exercise program.

9. The issue of reasonableness and necessity of services for anxiety and depression were raised in an addendum to the November 4, 2004 RME that was referred to in Carrier's EOB for the disputed services, but only in relation to not being reasonable and necessary for the work-related injury.

10. In its EOB for the CPM service, Carrier did not clearly raise the issue of medical necessity in relation to anxiety and depression for the disputed CPM and did not use the correct denial code for an extent-of-injury dispute.

11. Carrier submitted a TWCC PLN11 filing to the Commission on January 12, 2005, asserting an "extent of injury" dispute, in which it contended Claimant was being treated for anxiety and depression that were unrelated to his injury.

12. The TWCC PLN11 was not delivered to Provider.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.
2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

3. Carrier had the burden of proof in this matter, pursuant to 28 TEX. ADMIN. CODE§148.14.

4. Carrier's preauthorization of treatment precludes a challenge to payment based on medical necessity. TEX. LAB. CODE ANN. §413.014(e) and 28 TEX. ADMIN. CODE §133.301(a).

5. If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, it must send to MRD, 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 the employee. TEX. LAB. CODE ANN. §408.027(e).

6. Whenan insurance carrier denies payment on a medical bill, it is required to send an EOB that includes the correct payment exception codes and a sufficient explanation to allow the sender to understand the reason or reasons for the insurance carrier's actions. TEX. ADMIN. CODE §133.304(c).

7. Based on the Findings of Fact and Conclusions of Law, Carrier's appeal of the Texas Workers' Compensation Commission Medical Review Division decision should be denied.

8. SOAH does not have jurisdiction to determine the extent-of-injury dispute contained in Carrier's TWCC PLN11 filing with the Division. TEX. LAB. CODE ANN. ch. 410.

9. SOAH is not authorized to order payment for Provider's CPM services before the extent-of-injury decision pending at the Division is decided.

ORDER

IT IS, THEREFORE, ORDERED that the appeal of Continental Western Casualty Insurance Company from the Texas Workers' Compensation Commission Medical Review Division's decision on the medical necessity of a chronic pain management program provided to Claimant from November 29, 2004, through December 23, 2004, be, and the same is hereby, denied.

IT IS ORDERED FURTHER that the State Office of Administrative Hearings is not authorized at this time to order Continental Casualty Insurance Company to pay for the chronic pain management services because of Carrier's pending January 12, 2005, PLN11 filing with the Division.

IT IS ORDERED FURTHER that final action in this case is abated and this decision and order is not final pending the Division's decision on Carrier's January 12, 2005 PLN11 filing. When the PLN11 filing is decided or otherwise disposed of, either party may submit evidence of that action

and request the ALJ to take appropriate action, including ordering Carrier to pay for the chronic pain management program or ordering that the State Office of Administrative Hearings does not have authority to order payment. In addition, either party may request that the abatement be terminated or seek any other appropriate relief.

SIGNED May 3, 2006.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS