SOAH DOCKET NO. 454-08-3847.M5
TDI-DWC MFDR NO. M5-08-0096-01

SAFETY NATIONAL CASUALTY CORPORATION,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
DALLAS MULTIDISCIPLINARY/ DALLAS INTEGRATED HEALTHCARE,	§	
	§	
	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Safety National Casualty Corporation (Carrier) appealed from an adverse Medical Dispute Resolution decision issued by the Texas Department of Insurance, Division of Workers' Compensation (Division) ordering it to reimburse Dallas Multidisciplinary Clinic/Dallas Integrated Healthcare (Provider) for physical therapy services rendered between January 9, 2006, and March 15, 2006, for Claimant ____. A total of $ 4,298.61 was in dispute regarding the physical therapy that Provider administered.

The ALJ concluded that Carrier failed to establish that the Division's medical fee dispute resolution decision was in error. Provider administered physical therapy services that treated Claimant's compensable injury so Carrier should reimburse Provider the billed amount.

I. Jurisdiction, Notice, and Procedural History

The hearing convened October 22, 2008, before ALJ Cassandra J. Church in Austin, Texas, and the record closed that day. Carrier was represented by S. Rhett Robinson, attorney, and Provider was represented by Matthew Lewis, attorney. The parties offered competent evidence establishing jurisdiction and also that the Division provided appropriate notice of the hearing to the parties.

II. SUMMARY OF DISPUTE AND APPLICABLE LAW

A. History of the Case

Claimant suffered a back injury on _____, when he was bumped or hit by a forklift.[1] On August 22, 2005, Claimant underwent a spinal fusion of the L4-L5 levels. Claimant had not undertaken any physical therapy after the surgery.[2] On December 29, 2005, and February 2, 2006, Carrier preauthorized 24 sessions of physical therapy. In both pre-authorization letters, Carrier stated that it was disputing the extent of injury to exclude any degenerative changes and also any psychological issues.[3]

Provider provided services to Claimant on several dates between January 9, 2006, and March 15, 2006, billing a total of $ 4,298.61.[4] Those services included assisting Claimant perform stretching and range of motion exercises for the lumbar spine as well as administering ultrasound and traction, making chiropractic adjustments, and electrically stimulating the lumbar spine.[5] Except for the chiropractic adjustments, Provider's treatment notes did not identify a particular zone of the lumbar spine to which any of the procedures was directed. On January 9, 2006, Provider's staff adjusted the L5 vertebra; on January 17 and 19, the C5, C6, T4, and L5 vertebrae.[6] Claimant was ruled capable of returning to work in March 2006, with restrictions.

In April 2005, R. A. Buczek, D.O., D.C., conducted a retrospective peer review of Claimant's case and concluded that Claimant's compensable injury was limited to a lumbar strain, that any psychological symptoms pre-dated the compensable injury, and recommended against further diagnostic testing, chiropractic treatments, or physical medicine treatment. However, Dr. Buczek also recommended a course of facet injections to address the source of Claimant's

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[1] Provider Ex. 2, p. 21.

[2] Provider Ex. 2, p. 17.

[3] Provider Ex. 1, pp. 17 – 20.

[4] Similar services were provided in other months in 2006, but they are not at issue here. Provider Exs. 2 and 4.

[5] Provider Ex. 2, pp. 8 – 58.

[6] Provider Ex. 2, pp. 13, 40, and 55.

ongoing back pain, and up to 24 sessions of physical therapy to be followed by either a course of work hardening or a combination of work conditioning and a return-to-work program.

In January 2005, before Dr. Buczek's review, Carrier had initiated its challenge to the extent of Claimant's injury, with that proceeding running parallel to the ongoing treatment program. In an administrative decision issued on July 17, 2006, the Division concurred with Carrier that the compensable injury was limited to a lumbar strain.[7] Excluded from the compensable injury were a disc bulge, disc dehydration, and other degenerative conditions that doctors had observed in Claimant's lumbar spine and also the psychological issues.

Carrier denied payment for all dates of service in early 2006 on the bases that compensation was not warranted based on the peer review and also that Provider had failed to provide enough information to enable it to adjudicate the claim.[8] Provider sought medical dispute resolution (MDR) review, and on June 20, 2008, Donna Aubry, a Dispute Resolution Officer (DRO) with the Division, ruled in favor of Provider for all dates of service in January 2006.[9] Carrier timely requested a contested-case hearing at the State Office of Administrative Hearings (SOAH).

B. Summary of Dispute

Carrier asserted that, notwithstanding its preauthorization for treatment, it was entitled to conduct a retrospective review regarding the scope of services provided and proper billing procedures. It did not dispute that it was barred from disputing the medical necessity for the treatment, but contended that it had not done so. Carrier asserted that Provider treated only the disputed degenerative conditions, based on diagnosis codes listed on Provider's records. Carrier also asserted that Provider had assumed the risk of possible non-payment for services that entailed treatment for any disputed body area or condition, because preauthorization does not constitute a guarantee of payment.

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[7] Carrier Ex. 2, p. 3.

[8] Provider Ex. 2, p. 35.

[9] Provider Ex. 1.

Carrier also asserted that its notification to Provider of its extent-of-injury challenge via the preauthorization letters was sufficient notification to Provider that it would, most likely, deny payment on the grounds extent of injury.[10] Carrier acknowledged that the Explanation of Benefits (EOB) did not specifically state that an extent-of-injury challenge was pending, but contended that failure to do so did not waive its claim to pursue that issue through MDR. Carrier noted that the preauthorization letters had not only stated that such a claim was in progress, but also listed which elements of Claimant's diagnosis it was challenging. In short, Carrier asserted that the DRO was in error and that Provider's claim should be denied in its entirety.

Provider contended that the treatment it provided in January 2006 was general back therapy that addressed Claimant's lumbar strain and post-surgery rehabilitation, thus fit within the terms of the preauthorization. Provider also claimed that Carrier misread the purpose of the CPT codes listed on its medical records, asserting that those codes described symptoms observed by Provider's staff and did not constitute diagnosis codes for treatment purposes.[11] Provider further contended that Carrier wrongfully challenged medical necessity by referencing an adverse peer review as its reason for denial, terming the phrase peer review a shorthand way of asserting lack of medical necessity.[12] Provider also contended that Carrier waived its right to bring the extent-of-injury claim forward to MDR because it failed to list that reason on the EOB as required by the applicable administrative rules. In sum, Provider contended that the DRO's decision was correct and that Carrier should be required to reimburse Provider for all charges at issue.

C. Applicable Law

An injured worker who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.[13] A carrier is not required to

[10] Carrier Ex. 2.

[11] Provider Ex. 2, pp. 36, 47, 51.

[12] Carrier used denial code "270" for its objection to the treatment based on a peer review. Provider asserted that the proper ways to challenge the relatedness of treatment would have been using denial codes "E," "W," or the inclusion of an explanatory sentence.

[13] TEX. LAB. CODE ANN. § 408.021.

pay for medical treatment that does not address the compensable injury, even if both the compensable and non-compensable conditions are treated at the same time. A carrier may retrospectively review a bill and pay for or deny payment for medical benefits in accordance with the Act,[14] rules, and applicable Division fee and treatment guidelines. In general, a carrier may review the medical necessity and reasonableness of the health care that has been provided.[15] Specifically, a carrier may evaluate whether the provider has charged the appropriate fee if there are fee guidelines, ascertain a fair and reasonable reimbursement if no fee guidelines are in place, and also assess the medical necessity for the treatment, the extent of injury, and the relationship of the health care provided to the compensable injury.[16] However, if a carrier preauthorizes treatment, it is barred from thereafter disputing the medical necessity of that treatment.[17]

In denying payment, a carrier must inform the affected parties in a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee.[18] Rules adopted pursuant to the Act state that in its written ruling of payment of a claim, the EOB, a carrier must set forth the reasons for denying payment. One of those reasons may include an assertion the treatment is unrelated to the compensable injury.[19] The scope of an MDR is limited to these reasons presented to the requestor, *i.e.*, a provider or injured employee, prior to the date the request for MDR was filed with the Division and the other party.[20]

III. DISCUSSION

Carrier's assertion that Provider treated body areas other than the area of the lumbar spine that was injured or treated non-compensable conditions is not backed up by the medical records

[14] TEX. LAB. CODE ANN Title 5, Workers' Compensation (the Act).

[15] TEX. LAB. CODE ANN. § 133.2 (8).

[16] 28 TEX. ADMIN CODE § 133.230(b).

[17] 28 TEX. ADMIN CODE § 133.240(b).

[18] TEX. LAB. CODE ANN § 408.027(e).

[19] 28 TEX. ADMIN. CODE 133.240(e).

[20] 28 TEX. ADMIN CODE § 133.307(d)(2)(B).

in this case. Although the treatment notes lack some specificity in the description of the exercises undertaken and the progress made, they nevertheless describe only treatments administered to the lumbar spine. Unlike an area-specific treatment such a facet or epidural injection or a surgical procedure on a specific spine level, physical therapy will necessarily involve body areas adjacent to the injured area. The only treatments that were applied to a body area other than the lumbar spine are the adjustments discussed above. These do not appear to have been a regular occurrence or pervasive practice, so the ALJ concluded they were incidental to the primary course of therapy to the lower back.

Although Carrier asserted that the treatment targeted other conditions, it did not demonstrate how therapy for degenerative conditions would differ from that for a lumbar strain and post-surgery rehabilitation, nor that Provider administered therapy inappropriate for the compensable injury. The credible medical evidence in the record showed treatment consistent with the terms of the preauthorization.

Although Carrier's initial reliance on the diagnostic codes was reasonable, those codes are not a substitute for the description of the treatment itself provided in the SOAP notes. Provider failed to provide any explanation of why it chose to identify symptoms in areas of forms clearly labeled "diagnosis codes;" nevertheless, their descriptions are not the heart of the medical evidence in this case so are not dispositive. Carrier did not assert that Provider did not administer physical therapy as contemplated by the preauthorization.[21]

The issue of whether Carrier waived its right to bring forward its extent-of-injury challenge in the MDR proceeding, hence to SOAH, appeared to have been addressed by the DRO. The parties apparently supplied her with enough information about that claim to enable her to consider it in the decision-making process. The DRO did not discuss the waiver claim, suggesting that Provider did not raise the waiver claim at the MDR proceeding. Further, Provider cannot assert that it was surprised by Carrier's argument regarding the extent of the compensable injury, as Carrier

[21] Carrier apparently did not object to physical therapy administered between March 6, 2006, the last date of treatment authorized, and March 15, 2006, apparently the last date of actual treatment. The ALJ has assumed this was resolved between the parties before the medical dispute resolution.

had provided Provider with a clear and detailed statement of its position in both preauthorization letters. Provider's assertion that the use of a peer review usually signals a medical necessity argument has merit, as a peer review is frequently the basis of a medical necessity challenge. However, in this case, the peer review supports both the need for the treatment provided as well as recommending reducing the scope of the compensable injury. Thus, based on the facts in this case, the ambiguous peer review report is not sufficient to support a conclusion that Carrier waived its right to take the extent-of-injury claim to MDR.

On the basis of the above, the ALJ concludes that Carrier failed to carry its burden of proof to show that the Division's MDR decision was in error. The preponderance of credible medical evidence demonstrated that Provider administered a course of physical therapy for Claimant's lumbar strain and to aid in recovery from surgery. The effect of these conclusions is that the ALJ will order that Carrier reimburse Provider for the disputed services.

IV. FINDINGS OF FACT

1. On ___, ____ (Claimant) injured his low back when he was bumped or hit by a forklift.

2. Safety National Casualty Corporation (Carrier) was the responsible workers' compensation insurance carrier.

3. On August 22, 2005, Claimant underwent surgery to fuse the L4-L5 levels of his spine.

4. Claimant did not undertake any physical therapy immediately after his surgery.

5. In January 2005, Carrier initiated a challenge to findings on the extent of Claimant's injury, seeking to exclude degenerative spine conditions and psychological issues from the scope of the compensable injury.

6. In April 2005, R. A. Buczek, D.O., D.C., conducted a retrospective peer review of Claimant's case and concluded that Claimant's compensable injury was limited to a lumbar strain, that any psychological symptoms pre-dated the compensable injury, and that that no further diagnostic testing, chiropractic treatments, or physical medicine treatment were reasonable or necessary to treat the lumbar strain.

7. Dr. Buczek recommended a course of facet injections to address the source of Claimant's ongoing back pain, and up to 24 sessions of physical therapy to be followed by either a

course of work hardening or a combination of work conditioning and a return-to-work program.

8. On December 29, 2005, and February 2, 2006, Carrier preauthorized Dallas Multidisciplinary/Dallas Integrated Healthcare (Provider) to conduct up to 24 sessions of physical therapy between December 28, 2005, and March 6, 2006.

9. In the preauthorization letters issued on December 29, 2006, and February 2, 2006, Carrier stated that a challenge to the extent of Claimant's compensable injury was under way and identified the specific conditions or diagnoses it challenged, *i.e.*, degenerative spinal conditions and psychological symptoms.

10. In the two preauthorization letters, Carrier stated that, as no physical therapy had been undertaken following Claimant's spinal fusion on August 22, 2005, physical therapy would be appropriate to maximize Claimant's recovery from the surgical procedure.

11. On July 17, 2006, the Texas Department of Insurance, Division of Workers' Compensation (Division) issued a decision limiting the extent of Claimant's injury to a lumbar strain.

12. On several dates between January 9, 2006, and March 15, 2006, Provider conducted a physical therapy treatment program for Claimant that included assisted stretching and range of motion exercises for the lumbar spine, ultrasound and traction, chiropractic adjustment, and electrical stimulation of the lumbar spine.

13. In connection with the other modalities, Provider's staff adjusted Claimant's L5 vertebra on January 9, 2006, and the C5-C6, T4, and L5 vertebrae on January 17 and 19, 2006. These are the only adjustments that identified the zones of the spine to which treatment was administered.

14. Carrier did not object to treatments administered between March 6, 2006, the last date for which treatment was preauthorized, and March 15, 2006, the last date on which treatment was administered.

15. The course of physical therapy administered by Provider treated Claimant's lumbar strain and aided post-surgery rehabilitation.

16. By March 2006, Claimant had the capacity to return to work with some restrictions.

17. The course of physical therapy did not target body areas or parts other than the lumbar spine, inclusive of the L4-L5 spine level injured on _____, although other levels of Claimant's spine may have been treated incident to the primary treatment.

18. Provider sought reimbursement for a total of $4,298.61 for physical therapy provided between January 9, and March 15, 2006.

19. Provider's bills listed CPT codes, described on those bills as diagnosis or nature of illness or injury codes, which identified several degenerative spinal conditions. The bills did not list the diagnosis code for lumbar sprains and strains, *i.e.*, CPT Code 847.2.

20. After conducting a retrospective review of Provider's bills, Carrier denied payment for all physical therapy services performed by Provider between January 9, 2006, and March 15, 2006.

21. In the Explanations of Benefits (EOBs) it prepared, Carrier denied reimbursement for the physical therapy on the grounds that it was not eligible for payment based on a peer review and also that Provider had failed to provide enough information to enable it to adjudicate the claim.

22. Provider timely requested medical dispute resolution.

23. On June 20, 2008, the Division's medical dispute resolution officer concluded that Carrier incorrectly denied reimbursement for physical therapy that had been provided under the terms of the preauthorization and that the grounds of lack of information was inapplicable to the circumstances.

24. On July 18, 2008, Carrier requested a contested case hearing and the case was referred to the State Office of Administrative Hearings (SOAH).

25. On August 5, 2008, the Division issued a notice of administrative hearing for a contested case at SOAH.

26. The Notice of Hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the 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.

27. ALJ Cassandra J. Church convened the hearing on October 22, 2008, in Austin, Texas, and the record closed that day.

V. 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. LAB. CODE ANN. § 413.031.

2. Adequate and timely notice of the hearing issued by the Division conformed to the requirements of TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Carrier was entitled to conduct a retrospective review of Provider's medical bill, excluding the medical necessity for the preauthorized treatment, pursuant to TEX. LAB. CODE ANN. §§ 133.2(8) and 133.240(b).

4. Carrier had the burden of proving by the preponderance of the evidence that the medical dispute resolution decision on reimbursement was in error and that it properly denied reimbursement, pursuant to 28 TEX. ADMIN CODE § 148.14(a).

5. Based on the above Findings of Fact, Carrier failed to meet its burden of proof to show that Provider administered a course of physical therapy that was unrelated to the compensable injury, pursuant to 28 TEX. ADMIN. CODE § 133.230(b)(3).

6. Based on the above Findings of Fact and Conclusions of Law, Carrier failed to meet its burden of proof to show that it was entitled to deny Provider reimbursement for the disputed service.

ORDER

IT IS THEREFORE, ORDERED that Safety National Casualty Corporation is required to reimburse Dallas Multidisciplinary/Dallas Integrated Healthcare for physical therapy services performed between January 9, 2006, and March 15, 2006, for Claimant ____.

SIGNED December 18, 2008.

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CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS