SOAH DOCKET NO. 453-04-4454.M4

ALLIED MULTICARE CENTERS , Petitioner	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
AMERICAN MANUFACTURERS MUTUAL, Respondent	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner, Allied Multicare Centers seeks reimbursement of $25,560 from American Manufacturers Mutual for services provided in a chronic pain management program for workers' compensation claimant ____between July 2002 and September 2002. The Texas Workers' Compensation Commission's Medical Review Division (MRD) denied the reimbursement and the Petitioner challenges that decision. This decision finds that the Petitioner is entitled to reimbursement in the amount of $19,872 for the disputed services.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

There are no contested issues of notice or jurisdiction in this proceeding, and these matters are addressed in the findings of fact and conclusions of law. The hearing convened and closed June 24, 2004, before Administrative Law Judge (ALJ) Kerry D. Sullivan. Keith Allen Garner represented the Petitioner. Brandi M. Young represented the Carrier.

II. BASIS FOR DECISION

The Carrier's explanations of benefits (EOBs) denied benefits under four different denial codes: V (unnecessary treatment with peer review); U (unnecessary treatment without peer review); C (negotiated contract price); and R (extent of injury). Dealing first with the necessity-based codes

(U and V), the Carrier denied treatment for dates of service July 10 through July 24 based on V, and for the September 5 date of service using denial code U. The Petitioner is correct that denial cannot

appropriately be based on these codes because the services were preauthorized. Once a Carrier has preauthorized medical services, the Commission's rules specifically prohibit it from challenging the services on the grounds of medical necessity.[1]

Denial was also inappropriate based on the other codes the Carrier used. There is no indication in the record that the parties negotiated a contract price. The Carrier pointed out that it consistently reimbursed the Petitioner $200 for each reimbursement of billing code 9779 for chronic pain management, but there is no evidence of an *agreed* arrangement that this was the amount to be paid for each session. To the contrary, the Petitioner's answers to requests for information specifically state that the Petitioner did not have a contract with the Carrier for the services in dispute.[2] There is no basis in this record to infer or assume the existence of a contract. Accordingly, the C code is inapplicable.

Finally, at hearing, the parties stipulated that there is no dispute regarding the extent of the Claimant's injury. Accordingly, the denial of services under denial code R was also erroneous.

Rather than reviewing the propriety of the Carrier's stated reasons for denial, the MRD denied reimbursement for all services on the basis that the service provider did not adequately document them. As noted by the Petitioner, however, a denial on this basis should have used denial code N for Not Appropriately Documented.[3] Section 413.031 of the Act provides for medical dispute resolution at the Commission. Review at the MRD consists of a paper review of documents submitted by the parties, and these documents define the scope of the MRD dispute. It follows,

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[1] 28 TEX. ADMIN. CODE ' 133.301(a).

[2] Pet. Ex. 1, p 2.

[3] The Carrier must explain its reasons on Form TWCC-62, Notice of Medical Payment Dispute, or its equivalent. 28 TEX. ADMIN. CODE ' 133.304(a). This form sets out the appropriate denial codes and definitions.

therefore, that a carrier may not, for the first time in the SOAH proceeding, raise a basis for denying payment that it did not present to the provider or to the MRD. Because the Carrier did not raise the issue, it was waived.[4] Therefore, the ALJ will not deny reimbursement based on lack of documentation.

Based on the foregoing, the ALJ finds that the Petitioner is entitled to total reimbursement of $25,560 for the services in dispute.[5] Because the Table of Disputed Services indicates the Carrier has already reimbursed the Petitioner a total of $5,688,[6] the Carrier is ordered to provide the Petitioner additional reimbursement of $19,872.

III. FINDINGS OF FACT

1. On ____, the Claimant, sustained a compensable work-related injury.

2. At the time of the injury, American Manufactures Mutual Insurance was the worker's compensation carrier for the Claimant's employer.

3. The Claimant's treating physician ordered a chronic pain management program for the Claimant.

4. The Carrier preauthorized the requested chronic pain management program.

5. Allied Multicare Centers, the service provider, submitted charges of $25,560 for the services associated with the chronic pain management program which remain in dispute.

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[4] This assessment is consistent with SOAH precedent on this issue and applies even where it is the MRD rather than the Carrier that injects the new basis for denial into the proceeding. *See, e.g.*, Docket Nos. 453-96-1446.M4 (Nov. 12, 1996), Docket No. 453-97-0973.M4 (May 14, 1998), and Docket Nos. 453-02-0139.M2 (January 6,2003).

[5] The Petitioner initially requested reimbursement of an additional $3,019; at hearing, however, it reduced its request by this amount, apparently in order to remove dates of service for which the Carrier did, in fact, deny reimbursement based on lack of documentation. As indicated in the text, the Carrier did not identify documentation as the basis for denial of any of the items remaining in controversy.

[6] Pet. Ex. 1, pp. 84-85.

6. The Carrier reimbursed the Carrier $5,688, but denied the other charges using four different denial codes: V (unnecessary treatment with peer review); U (unnecessary treatment without peer review); C (negotiated contract price); and R (extent of injury).

7. The Petitioner and the Carrier did not negotiate a price for the services in dispute in this proceeding.

8. The parties have stipulated that the extent of the claimant's injury is not in dispute.

9. On February 12, 2004, the MRD issued a decision denying reimbursement for all services based on lack of adequate documentation.

10. A denial of reimbursement based on lack of documentation should be made based on denial code AN@ on Form TWCC-62, Notice of Medical Payment Dispute, or its equivalent.

11. The Petitioner timely contested the IRO decision.

12. On April 13, 2004, the Commission sent a notice of hearing to the parties. The notice contained a statement of the time and place of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular section of the statutes and rules involved; and a short plain statement of the matters asserted.

13. The hearing on the merits was convened on June 24, 2004 before Administrative Law Judge Kerry D. Sullivan. Keith Allen Garner represented the Petitioner. Brandi M. Young represented the Carrier.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction to decide the issues presented pursuant to the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. ' 413.031.

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 ' 413.031(k) of the Act; TEX. GOV'T CODE ANN. ch. 2003, and 28 TEX. ADMIN. CODE (TAC) chs. 148 and 149.

3. Petitioner timely appealed the MRD's decision pursuant to 28 TAC ' 148.3.

4. The Commission sent a notice of hearing that complied with the requirements of TEX. GOV'T CODE '' 2001.001, 2001.052, and 28 TAC ' 148.4(b).

5. Petitioner had the burden of proof to show by a preponderance of the evidence that it should prevail in this matter, pursuant to 28 TAC ' 148.21(h).

6. Once a Carrier has preauthorized medical services, it may not subsequently challenge the services on the grounds of medical necessity. 28 TEX. ADMIN. CODE ' 133.301(a).

7. Section 408.021 of the Act and 28 TAC ' 134.1, provide that health care providers shall bill carriers only for treatments and services rendered that are medically necessary to treat the compensable injury, and in accordance with Commission rules and guidelines.

8. If a carrier has not informed the health care provider of a particular reason for denial prior to the provider's request for medical dispute resolution, the carrier cannot change or add a denial code after a dispute is at the MRD for review or at a contested case hearing before SOAH. ' 408.027(d) of the Act and 28 TAC ' 133.304(a).

9. Because denial of benefits was not appropriate for the reasons given by the Carrier, the Petitioner is entitled to reimbursement of the expenses denied by the Carrier.

ORDER

It is hereby ordered that American Manufacturers Insurance Company shall reimburse Allied Multicare Centers $19,872 for the disputed services provided to the Claimant between July 10, 2002 and September 6, 2002.

SIGNED this 23rd day of August, 2004.

KERRY D. SULLIVAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS