SOAH DOCKET NO. 454-09-5024.M4
DWC MR NO. M4-09-7521-01

KILLEEN INJURY CLINIC, INC., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
UNION STANDARD INSURANCE CO., **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Killeen Injury Clinic (Provider) requested a hearing to contest a medical fee dispute resolution order issued by the Texas Department of Insurance, Division of Workers' Compensation (Division) regarding $5,265.80 in medical services provided to ___ (Claimant). In its order, the Division found that Petitioner was not entitled to reimbursement from Union Standard Insurance Co. (Carrier). After considering the evidence and the arguments presented, the Administrative Law Judge (ALJ) finds that Provider is entitled to reimbursement of $5,265.80.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

There are no contested issues of notice or venue in this proceeding. These matters are addressed in the findings of fact and conclusions of law without further discussion. A question concerning jurisdiction will be discussed below.

The hearing on the merits convened on December 7, 2009, before ALJ Paul D. Keeper at the State Office of Administrative Hearings (SOAH), Austin, Texas. Provider was represented by Attorney Allen T. Craddock. Carrier was represented by Attorney Steven M. Tipton. The hearing concluded that same day, but the record did not close until January 8, 2010, after written closing arguments were submitted.

Due to docket considerations, this case was reassigned to ALJ Roy G. Scudday, who received the record and issues this Decision and Order.

II. DISCUSSION

A. Background

On ___, Claimant, an employee of ___, was injured while lifting a heavy truck part from the back of a truck. Prior to the incident, Claimant had suffered low back injuries, was diagnosed with lumbar disc herniations, radiculopathy, and degenerative disc disease, and had ongoing problems with a low back stimulator battery pack that was scheduled to be replaced in ___. After the incident, Claimant contended that the incident exacerbated her preexisting conditions, caused her to be depressed, and required an additional stimulator.

On June 26, 2008, Provider sought preauthorization from Carrier to provide ten sessions of an outpatient work hardening program as related to the lumbar spine.[1] The Notice of Utilization Review Findings issued June 27, 2008, identified treatment diagnosis code 847.2 "sprain lumbar region" and preauthorized ten sessions of outpatient work hardening.

From July 2, 2008 through July 28, 2008, Provider rendered ten work hardening sessions to Claimant and billed Carrier a total of $5,265.80 for these sessions. The bills and treatment records for the July 2, 24, 25, and 28 work hardening sessions were under diagnosis code 847.2. The bills and treatment records for the July 8, 9, 11, 14, and 15 work hardening sessions and for the July 16 performance evaluation were under diagnosis codes 847.2 and 722.10 "lumbar disc displacement."[2] The claims were initially submitted in July 2008.

Carrier denied the claims for the July 24, 25, and 28 sessions in August 2008, pending adjudication of an extent of injury issue. (A compensable injury decision (CCH) that the compensable injury did not include lumbar disc herniations, radiculopathy, degenerative disc disease, and depression had become final on ___.)[3] Carrier did not issue an explanation of benefits

[1] Petitioner's Ex. Nos. 6 and 7.

[2] Respondent's Ex. No. 3.

[3] Respondent's Ex. No. 3.

(EOB) for the original claims for the July 2, 8, 9, 11, 14, 15, or 16 sessions.

On July 25, 2008, Provider submitted corrected claims under only the 847.2 code for all the sessions through July 16, 2008.[4] On October 1 and 15, 2008, Provider resubmitted the three claims that had been denied for extent of injury. On October 28, 2008, Carrier denied all the claims.

A Medical Fee Disposition Resolution Decision (MRD) issued June 8, 2009, found that Provider's corrected claims were in fact requests for reconsideration that failed to reference the original bills and include the same billing codes, dates of service, and dollar amounts as the original bills, as required by 133 TEX. ADMIN. CODE (TAC) § 133.250(d) (1). As a result, the MRD determined that the request for fee dispute resolution was premature.

B. Carrier's Motion to Dismiss

Carrier moved to dismiss this action based on the finding of the MRD, contending that Provider merely changed the original diagnosis codes in its Request for Reconsideration. Provider responds that the finding of the MRD did not resolve the issue of Provider's entitlement to reimbursement for the services provided.

The rule at 28 TAC § 133.20 concerns medical bills submission by health care providers. Subsection (b) of the rule provides that the provider "shall not submit a medical bill later than the 95th day after the date the services are provided." Subsection (c) provides that the provider shall include "correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Subsection (g) provides that providers "may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." The rule at 28 TAC § 133.250(a) provides that if the provider "is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider the action."

[4] Petitioner's Ex. No. 5 at page 1.

Based on the above-stated rules, it is clear that the bills submitted on July 25, 2008, were corrected bills with the proper diagnosis code for the sessions from July 8 through July 16, 2008, not requests for reconsideration as found by the MRD. The bills were timely submitted under the rule and were denied by the Carrier. As a result, they are a proper a part of this proceeding.

As for the bills for the July 22, 24, and 28 sessions, they were not the subject of final action by Carrier until October 2008. As a result, they too are a proper part of this proceeding. Accordingly, Carrier's Motion to Dismiss is denied.

C. Fee Dispute

Provider argues that Carrier is required to make the reimbursement sought because Carrier preauthorized the work hardening program, citing 28 TAC § 134.600(c) (1) (B). All non-exempted work hardening programs require such preauthorization pursuant to 28 TAC § 134.600(p).

Subsection (l) (3) of the rule provides that the preauthorization approval shall include "a notice of any unresolved dispute regarding the deniability of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury." As pointed out by Carrier, if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury, Carrier is not liable for the reimbursement, citing subsection (d) of the Rule.

Carrier contends that Claimant's compensable lumbar sprain injury was not the basis for the services rendered by Provider. Therefore, Carrier argues it is not liable for reimbursement of any of the services.

Provider argues that (1) the compensable injury only has to be part of the treatment, not the sole reason for the treatment, (2) Carrier waived its right to dispute payment by failing to act timely on the bills submitted after the services were performed, and (3) the effect of the preauthorization is that Carrier cannot later contest the reasonableness and necessity for the treatment.

D. Analysis

Addressing Provider's third point first, the preauthorization approval cited "sprain lumbar region" as the diagnosis and specifically authorized the ten sessions of a work hardening program. However, the preauthorization approval also noted that there was a pending dispute regarding the lumbar disc herniations, radiculopathy, degenerative disc disease, and depression that could result in denial of reimbursement for the services due to the issue of extent of the injury. Clearly, under the rule Carrier could still dispute whether the approved treatment was actually for the lumbar sprain or for the preexisting conditions.

Provider argues that because the determination of no compensation for the preexisting conditions had been made prior to the issuance of preauthorization approval, there was nothing pending in that regard. Because the CCH had not become final before the preauthorization approval was issued, it is not clear why the Carrier would issue the preauthorization approval in the first place if it questioned that the proposed treatments were actually for the preexisting conditions as opposed to the lumbar sprain.

Provider's second argument that Carrier waived the right to dispute the bill when it failed to take final action on the bill within 45 days is based on 28 TAC § 133.240 (a) and (n) that such failure is an administrative violation. However, Provider has submitted nothing to support its position that such an administrative violation amounts to a waiver of the right to dispute the bill.

The basic issue to be decided in this case is whether the treatment provided was related to the compensable injury of a lumbar strain. Provider argues that it was because that strain had exacerbated the preexisting conditions. Carrier argues that it was not because it was for the ongoing, long-standing chronic low back pain, radiculopathy and depression, which was not a compensable injury.

Provider cites SOAH Decision No. 454-09-5290 as support for its position. That Decision stated the following:

> It is undisputed that Carrier approved the treatment and limited the injury to a sprain/strain. Carrier also reviewed the bills which reflected the treatment was rendered under a sprain/strain diagnosis code, and stipulated in the Division's order

that Claimant suffered a cervical and lumbar sprain/strain.

> The ALJ finds Carrier's basis of denial to be disingenuous by taking the Division's finding (that Claimant's injury played no part in her displaced discs) and using it as a basis to deny reimbursement because Provider's preauthorization request diagnosed Claimant with displaced discs. This action fails to consider that Claimant was actually treated under a sprain/strain diagnosis, which benefited Claimant by returning her to work following the treatment.
>
> Under the circumstances presented, therefore, the ALJ concludes that the chronic pain management in issue was provided for Claimant's compensable back injury. Thus, Claimant's denial of reimbursement based upon the diagnosis codes on the preauthorization request is not justified.

While this Decision is instructive, it is not dispositive because the facts are different. In this case, the diagnosis on the preauthorization request was for a sprain of the lumbar region, which was supported by the CCH's finding. However the CCH also found that Claimant did not have a disability from ___, through the date of the hearing on ____ that was a result of the lumbar sprain. It is this finding that Carrier relies on to support its contention that the treatment provided in ___ was for the preexisting conditions as opposed to the lumbar strain injury. However, that finding is concerned with whether the Claimant was able to return to work on ___, not whether the subsequent treatment was related to the lumbar strain.

Although Carrier attempts to frame the case as such, this is not a case of Carrier's denying the reimbursement based on an incorrect diagnosis code used for a compensable injury, but, rather, whether Carrier's denial of the treatment because it was for a non-compensable preexisting condition was valid. While Provider's argument that it is unfair to allow the Carrier to come back after giving preauthorization approval to dispute treatment given pursuant to that approval has merit, the fact is that the rules allow just such an action by the Carrier. However, when the Carrier takes such an action after issuing the preauthorization, the burden is on the Carrier to show that the treatment was not related to the compensable injury.

In addition to the CCH, Carrier cites the following evidence to support its position that the work hardening sessions were not related to the lumbar strain but, rather, to the preexisting condition:

- The work hardening was designed to return Claimant to work. [5]
- A major element addressed by the program was Claimant's actual Axis I Diagnosis of "Adjustment Disorder with mixed anxiety and depressed mood, secondary to the work injury," which was contrary to the CCH. [6]
- The diagnosis used by the provider was the non-specific, generic (and non-existent) diagnosis of "low back pain." [7]
- Claimant was still complaining of radiculopathy. [8]
- Claimant's medication regimen of hydrocodone, Elavil, and Neurontin was inconsistent with a back strain that had resolved about 17 months before. [9]
- A significant component of the program was addressing the claimed, and non-compensable, depression. [10]

In response, Provider points out that 28 TAC § 137.100(a) provides that providers "shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Compensation,* (ODG). ODG Treatment Guidelines provide that work hardening programs are recommended for lower back injuries where the program has been recommended by a physician. In making the decision to recommend such treatment, the screening evaluation should include a history of previous injury, diagnosis, work status before the injury, work status after the injury, history of treatment for the injury including medications, and review of other non-work related medical conditions. Provider argues that the guidelines do not require that the compensable injury be the sole reason for the treatment program.

With no expert evidence in the record, the evidence and authorities must speak for themselves. Claimant had a pre-existing back condition that was exacerbated by the injury. The screening evaluation of Provider determined that the work hardening program was the proper

[5] Petitioner's Ex. No. 6 at page 40.

[6] Petitioner's Ex. No. 6 at page 16.

[7] Petitioner's Ex. No. 6 at pages 1, 3, 9, 11, 13, 15, 39, 41, 43, 46, and 48.

[8] Petitioner's Ex. No. 6 at page 16.

[9] Petitioner's Ex. No. 6 at page 16.

[10] Petitioner's Ex. No. 6 at page 27.

treatment for the injury, which necessarily would also treat the preexisting condition. The evidence cited by Carrier is insufficient to show that the preauthorized treatment was not related to the compensable injury.

In conclusion, the ALJ finds that Provider is entitled to reimbursement of $5,265.80 for the work hardening program services provided to Claimant. In support of this decision, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. ____ (Claimant) suffered a compensable injury ___, when she lifted a heavy truck part from the back of a truck

2. On the date of injury, Union Standard Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. Claimant received extensive treatment for her compensable injury.

4. On June 26, 2008, Killeen Injury Clinic (Provider) sought preauthorization from Carrier to provide ten sessions of work hardening treatment to Claimant.

5. On June 30, 2008, Carrier preauthorized ten sessions of a work hardening program as related to the lumbar spine, using diagnosis code 847.2 "sprain lumbar region."

6. On the preauthorization approval form, Carrier advised Provider that there was a pending dispute regarding the lumbar disc herniations, radiculopathy, degenerative disc disease, and depression that could result in denial of reimbursement for the services due to the issue of extent of the injury.

7. Between July 2 and July 28, 2008, Provider rendered ten sessions of work hardening to Claimant and billed Carrier a total of $5,265.80 for these sessions.

8. A decision that the compensable injury did not include lumbar disc herniations, radiculopathy, degenerative disc disease, and depression became final on ___.

9. The bills and treatment records for the July 2, 24, 25, and 28 work hardening sessions used diagnosis code 847.2. Carrier denied the claims for the July 24, 25, and 28 sessions in August 2008, pending adjudication of the extent of injury issue, despite the fact that the dispute had been settled by that time.

10. The bills and treatment records for the July 8, 9, 11, 14, and 15 work hardening sessions and for the July 16 performance evaluation used diagnosis codes 847.2 and 722.10 "lumbar disc

displacement." The claims were initially submitted in July 2008.

11. Carrier did not issue an explanation of benefits (EOB) for the original claims for the July 2, 8, 9, 11, 14, 15, or 16 sessions.

12. On July 25, 2008, Provider submitted corrected claims using only the 847.2 code for all the sessions through July 16, 2008. On October 1 and 15, 2008, Provider resubmitted the three claims that had originally been denied for extent of injury. On October 28, 2008, Carrier denied the corrected claims as well as the claims for the July 24, 25, and 28 sessions.

13. After Carrier denied reimbursement for the services, Provider requested medical fee dispute resolution through the Texas Department of Insurance, Division of Workers' Compensation (Division).

14. On June 8, 2009, Division found that Provider's corrected claims were in fact requests for reconsideration that failed to reference the original bills and include the same billing codes, dates of service, and dollar amounts as the original bills, and determined that the request for fee dispute resolution was premature.

15. On June 15, 2009, Provider requested a hearing by the State Office of Administrative Hearings (SOAH) to challenge the Division's order.

16. The Division referred the matter to SOAH on June 19, 2009.

17. All parties received adequate notice of not less than ten days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

18. On December 7, 2009, SOAH Administrative Law Judge (ALJ) Paul D. Keeper held a contested case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. At the hearing, Provider appeared through its attorney, Allen T. Craddock, and Carrier appeared through its attorney, Steven M. Tipton.

19. The record closed in this contested case on January 8, 2010. On January 26, 2010, the case was reassigned to ALJ Roy G. Scudday.

20. The work hardening program at issue in this case was provided for Claimant's compensable injury.

21. The reimbursement amount sought for the services provided in this case is $5,265.80.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ANN. §§ 402.073(b), 413.031, 413.0311, and 413.055; and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051-.052.

3. Carrier had the burden of proving by the preponderance of the evidence that the preauthorized treatment services were not related to the compensable injury. 1 TEX. ADMIN. CODE § 155.427.

4. Based on the above findings of fact and conclusions of law, Carrier is liable to Provider for $5,265.80, and is required to pay that amount to Provider, because the procedures in issue were properly preauthorized, were provided for Claimant's compensable injury, and have not been previously reimbursed by Carrier.

ORDER

THEREFORE, IT IS ORDERED THAT Union Standard Insurance Company is required to pay the sum of $5,265.80 to Killeen Injury Clinic in reimbursement for the work hardening program services at issue in this case.

SIGNED February 4, 2010.

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS