**SOAH DOCKET NO. 454-14-1702.M4-NP**
**MDR NO. _____**

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| **TEXAS MUTUAL INSURANCE COMPANY,** | § | **BEFORE THE STATE OFFICE** |
| **Petitioner** | § | |
| | § | |
| **v.** | § | **OF** |
| | § | |
| **TEXAS MEDICAL TOXICOLOGY,** | § | |
| **Respondent** | § | **ADMINISTRATIVE HEARINGS** |

# DECISION AND ORDER

## I. INTRODUCTION

This case involves clinical laboratory services rendered by Texas Medical Toxicology (TMT) to an injured employee covered by the workers' compensation insurance system. The Texas Department of Insurance's Division of Workers' Compensation (Division)[1] conducted medical dispute resolution (MDR) and ordered Texas Mutual Insurance Company (Carrier) to make an additional reimbursement to TMT of $319.43 plus interest.

Carrier has stipulated that this matter is a medical fee dispute, not a medical necessity dispute.[2] Carrier contends that the denial of payment was justified based on TMT's failure to provide required documentation with the bill which precluded Carrier from making a medical necessity determination. After considering all of the evidence and arguments, the Administrative Law Judge (ALJ) upholds the MDR determination, and Carrier is required to pay reimbursement as ordered by MDR.

[1] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation Commission (Commission) and created the Division of Workers' Compensation within the Texas Department of Insurance. Act of June 1, 2005, 79th Leg., R.S., ch. 265, § 8.001, 2005 Tex. Gen. Laws 469, 607. This Decision and Order refers to the Commission and its successor collectively as the Division.

[2] The ALJ notes that the State Office of Administrative Hearings (SOAH) does not have jurisdiction to adjudicate a medical necessity dispute.

## II. APPLICABLE LAW

At the outset of this decision, it is appropriate to set forth the legal backdrop for the workers' compensation reimbursement system. Workers' compensation insurance covers all medically-necessary health care, which includes all reasonable medical aid, examinations, treatments, diagnoses, evaluations, and services reasonably required by the nature of the compensable injury and reasonably intended to cure or relieve the effects naturally resulting from a compensable injury. It includes procedures designed to promote recovery or to enhance the injured worker's ability to return to or retain employment.[3]

Section 413.011 of the Act provides that the Division by rule shall establish medical policies and guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services. That section further provides that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.[4] Moreover, the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. In setting such guidelines, the increased security of payment afforded by the Act must be considered. The Division has adopted reimbursement guidelines for clinical laboratory services.[5]

Section 408.027(a) of the Act requires a health care provider to "submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee." A provider must submit a "complete bill" as defined in the applicable rules. A "complete bill" is one with all the required fields filled in.[6]

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[3] Tex. Lab. Code § 401.011(19), (31). The Texas Workers' Compensation Act is found at Texas Labor Code § 401.001 *et seq.* and is hereafter referred to as the "Act."

[4] Act § 413.011(d).

[5] 28 Tex. Admin. Code (TAC) § 134.203. The guidelines adopted by the Division are known as the Official Disability Guidelines (ODG).

[6] 28 TAC §§ 133.2(4), 133.10.

If the bill is not complete, the carrier may 1) fill in the missing information, 2) request additional information and fill in the missing information, or 3) return the bill. The carrier must include a document stating the reasons for returning the bill.[7]

Within 45 days after it receives a complete medical bill, an insurance carrier must conduct a bill review and determine to pay, reduce, deny, or audit the claim. The insurance carrier may request additional documentation not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.[8] If the insurance carrier makes a request for further documentation, the provider has 15 days to respond. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.[9] However, the carrier may conduct an audit to determine the medical necessity of a charge. If the carrier announces it intends to conduct an audit of the bill, it must pay 85 percent of the bill to the provider. It then has 160 days to collect information and make a decision on medical necessity. The health care provider is required to make available all documentation relevant to the bill that it has in its possession to the carrier during the audit. Within 160 days, the carrier must complete the audit and pay, deny, or reduce payment.[10] The carrier then has 40 days from the completion of the audit to demand a refund of payments made if it determines the charge was not medically necessary.[11] When the insurance carrier makes

[7] 28 TAC § 133.200.

[8] Act § 408.027(b), 28 TAC § 133.240(d).

[9] Act § 408.027(b), 28 TAC § 133.240(a).

[10] 28 TAC § 133.230

[11] 28 TAC § 133.260.

payment or denies payment on a medical bill, the insurance carrier must send to the health care provider the explanation of benefits (EOB) in the form and manner prescribed by the Division.[12]

If dissatisfied with the insurance carrier's final action, the health care provider may request the carrier to reconsider.[13] If the carrier still denies payment after reconsideration, the provider may request medical dispute resolution.[14] The health care provider has two different paths for appeal, depending on the nature of the dispute.[15] If the dispute concerns a medical necessity determination, the provider may request a review of the denial by an independent review organization (IRO).[16] If the carrier determines the services to be medically necessary and appropriate, but disputes the amount of payment due for those services, the dispute is characterized as a medical fee dispute and the Division conducts the medical fee dispute resolution.[17] If a dispute regarding medical necessity exists for the same service for which there is a medical fee dispute, the dispute regarding the medical necessity of the service shall be resolved prior to the submission of a medical fee dispute for the same service.[18] An appeal of a determination by an IRO regarding medical necessity is heard by a Division hearings examiner, while an appeal of a determination by the Division regarding a medical fee dispute is heard by an ALJ at the State Office of Administrative Hearings (SOAH).

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[12] 28 TAC § 133.240(e), (f). An EOB is required by the Act § 408.027(d), which provides: "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 the employee." The "report" referenced in § 408.027(e) of the Act is what is commonly referred to as an EOB ("explanation of benefits" sometimes also referred to as an "explanation of reimbursement" or "DWC 62"). Just as Division Rule 133.240 requires that the insurance carrier send the explanation of benefits in the form and manner prescribed by the Division, a carrier is required to send the explanation of benefits in the form and manner prescribed by the Division (again, the DWC 62) when responding to a request for reconsideration. 28 Tex. Admin. Code § 133.250(f).

[13] 28 TAC § 133.240(i).

[14] 28 TAC § 133.240 (j).

[15] 28 TAC § 133.305(a)(3).

[16] Act § 413.031(d), (e); 28 TAC § 133.305(a)(7).

[17] Act § 413.031(c); 28 TAC § 133.305.

[18] 28 TAC § 133.305(b).

A carrier may not raise a defense at MDR or at the SOAH hearing that the carrier failed to raise prior to the date the request for medical dispute resolution was filed.[19]

## III. DISCUSSION

### A. Burden of Proof

The ALJ concludes at the outset that the purpose of this docket is not to review the amounts ordered through MDR. Rather, SOAH hearings have historically involved a *de novo* review of the issues involved, and have not been simply a review of the propriety of the MDR decision. The *de novo* nature of SOAH hearings is not the result of specific statutes, applicable procedural rules, or case law requiring it. Rather, it has developed through past SOAH precedent—the same precedent which has, for more than 10 years, almost uniformly placed the burden of proof on the party requesting the SOAH hearing in medical fee dispute cases. In part, this comes from the recognition that the party requesting the SOAH hearing is the party seeking to change the status quo.

To give meaning to the rules and purposes behind the MDR process, SOAH ALJs have historically seen the MDR process as having three significant impacts: (1) it defines the scope of the dispute; (2) it limits the claims or defenses that may be raised; and (3) it sets the burden of proof in the SOAH proceeding. So, the fact that the SOAH hearing is a *de novo* proceeding means that the SOAH hearing is the proceeding of record (*i.e.*, where the evidentiary record is established) and, accordingly, the parties may present new evidence at the hearing not previously considered in MDR. However, the parties' claims and defenses are limited to those properly raised previously in MDR, and the status quo in the absence of a SOAH decision superseding it is the MDR order. The ALJ finds it appropriate to place the burden of proof on the party requesting relief from the MDR decision. In this case, that is Carrier.

### B. Evidence

[19] 28 TAC § 133.307(d)(2)(F).

Neither party submitted testimony in this case. Carrier submitted the underlying documentation consisting of (1) the bill, physician order, Carrier's EOB, and TMT's response (Ex. A); (2) the Medical Fee Dispute Resolution Request (MFDR) (Ex. B); (3) Carrier's response to MFDR (Ex. C); and (4) the MFDR decision (Ex. D). TMT submitted a letter from the ordering physician (Ex. 1). The facts were undisputed.

On December 7, 2012, TMT billed Carrier for medical services consisting of quantitative urine drug testing performed on September 10, 2012.[20] Included with the bill was the laboratory test report. TMT sought $467 in payment. On January 15, 2013, Carrier issued an EOB to TMT using the following codes[21] for nonpayment:

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| CAC-W1 | Workers compensation state fee schedule adjustment. |
| CAC-16 | Claim/Service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NDCPDP reject reason code). |
| CAC-97 | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| 217 | The value of this procedure is included in the value of another procedure performed on this date. |
| 225 | The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information. |
| 641 | The medically unlikely edits (MUE) from CMS has been applied to this procedure code. |
| 758 | ODG [Official Disability Guidelines] documentation requirements for urine drug testing have not been met. |
| 420 | Supplemental payment. |

[20] Carrier Ex. A at 4-5. TMT billed the services under Current Procedural Terminology (CPT) Codes 82570, 82520, 82542, 83925, 83925, 82649, and 82542.

[21] The Division directs the use of the ANSI adjustment code reasons. The complete ANSI Claim Adjustment Reason Code set is available on the Washington Publishing Company Code website at: www.wpc-edi.com. The Division also directs participants there from its own internal weblink at: http://www.tdi.texas.gov/wc/hcprovider/compconnection.html.

On February 21, 2013, TMT submitted a request for reconsideration to Carrier, explaining that TMT was "performing urine drug confirmation tests for multiple drugs using Liquid Chromatography/Mass Spectrometry (LCMS) to provide quantitative confirmation of drugs." In addition, TMT stated that the documents submitted indicated each separate drug being tested for. TMT attached the physician's order for the test.[22] On April 1, 2013, Carrier issued a second EOB, with the same nonpayment codes as on the January 15 explanation of benefits, adding:

> 891 No additional payment after reconsideration.

On April 22, 2013, TMT filed a Medical Fee Dispute Resolution Request with the Division.[23] On May 15, 2013, Carrier filed with the division a response to the request by TMT, stating:

> The issue involves [Carrier's] inability to make a medical necessity determination because of a lack of documentation. [Carrier's] principal denials in this dispute pertained to the lack of information (documentation) provided. As such *it constitutes a fee documentation denial, not a medical necessity denial.*[24]

In support of this position, Carrier cited Division's comments published in the Texas Register: "The health care provider is required to submit a complete medical bill and should include required documentation. If the health care provider fails to include required documentation, insurance carrier medical billing processes allow insurance carriers to request any necessary documentation or *deny medical bills for lack of documentation*."[25]

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[22] Carrier Ex. A at 2.

[23] Carrier Ex. B.

[24] Carrier Ex. C.

[25] Carrier Ex. C. Carrier cited 31 Tex Reg. 3544, 3548, May 2, 2006; however, the correct cite is to the April 28, 2006 issue. Carrier added the emphasis. The ALJ notes that, in the same published comment, the Division referred to Section 133.2, which defines a "complete medical bill" and Section133.210, which "establishes documentation requirements."

On September 3, 2013, the Division issued its Medical Fee Dispute Resolution Findings and conclusions. The Division found that TMT was entitled to reimbursement in the amount of $319.43.[26]

## C. ALJ's Analysis

Because this is a medical fee dispute, Carrier must establish by a preponderance of the evidence that the amount of the fee which TMT billed did not comply with reimbursement guidelines for clinical laboratory services as set out in Division rules. If Carrier fails to do so, then it is not entitled to relief from the MDR order and the ALJ will order reimbursement consistent with the MDR order. This is the outcome the ALJ reaches in this docket after considering the evidence and arguments of the parties.

At the hearing, Carrier presented no witnesses and no evidence to show that the amount TMT billed for the services in issue did not comply with reimbursement guidelines for clinical laboratory services as set out in Division rules. In fact, Carrier conceded it did not dispute that "if payment were due, the amount would be $319.43" as calculated in the MDR order.[27] Rather, it argued that TMT failed to provide the supporting documentation with the bill to allow Carrier to determine whether the services provided were medically necessary. This argument has no relevance to the issue raised by a medical fee dispute, as defined in Division rules. A medical fee dispute is defined as a dispute over the amount of payment for services that *have been determined to be medically necessary*.[28] Since this case is a medical fee dispute, not a medical necessity dispute, as stipulated by Carrier, it is presumed that the services were medically necessary, as a medical fee dispute only arises in a case where medical necessity has been established.

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[26] Carrier Ex. D.

[27] Carrier Closing Argument Brief at 4, fn.6.

[28] 28 TAC § 133.305(a)(5).

Carrier's characterization of the dispute as a "fee documentation denial" does not change Carrier's burden of proof. Neither the Act nor the rules reference an appealable dispute based solely on lack of adequate documentation; disputes are either based on medical necessity denials or medical fee denials. Carrier's attempt to create a new class of appeals simply masks the true nature of its argument, which is based on a medical necessity dispute not a fee dispute. This fact is amply illustrated by Carrier's references, in its response filed in the MDR, to prior SOAH dockets, all of which involved medical necessity disputes.[29] Those cases only reinforce the conclusion that, if Carrier denied the claim based on lack of documentation to substantiate medical necessity, Carrier should have followed the administrative procedures for a medical necessity denial, not a fee dispute denial.

Carrier argued that it would be left without a remedy if it were not allowed to base a fee dispute denial on lack of documentation necessary to make a medical necessity determination. To the contrary, Carrier had the option to return the bill to TMT if it believed the bill was not complete. Instead, Carrier issued an EOB denying payment, thereby implicitly acknowledging that the bill was complete. If Carrier had needed more time or information to determine medical necessity, it could have followed the procedure to audit the claim or conduct a retrospective review.[30] Carrier also had the option to deny the claim based on lack of medical necessity, if it concluded the documentation did not support medical necessity. Neither the Act nor the rules contemplate a situation where a carrier can base a denial simply on lack of documentation to establish medical necessity. Even if one could read such a right into the law, certainly such a dispute would not be characterized as a medical fee dispute.[31]

Carrier contends that Division rules place the onus on the provider to supply supporting documentation needed to make a medical necessity determination when the provider submits the

[29] Carrier Ex. C at 1-2, fn.1, 3, fn.3. The dockets referenced by Carrier were all decided when SOAH still had jurisdiction over medical necessity disputes.

[30] 28 TAC §§ 137.100; 19.2003.

[31] Carrier has cited old SOAH dockets when SOAH still had jurisdiction over medical necessity disputes. These dockets involved lack of sufficient documentation to establish medical necessity. The ALJ finds these dockets support a conclusion that lack of documentation to support medical necessity involves a medical necessity dispute, not a medical fee dispute. *See, e.g.,* SOAH Docket No. 453-02-0731.M5 (March 14, 2002).

medical bill. This argument is contradicted by the Act and Division rules. The Division's rule 133.210 states that the obligation of the provider is to provide the "required documentation" in legible form.[32] The required documentation is set out in rules 133.2 and 133.10, which define the requirements of a complete bill. If the bill is not complete, the carrier can either request additional documentation to make it complete, or return the bill without processing it.[33] Neither action constitutes an appealable medical fee denial or medical necessity denial.

In this case, Carrier does not dispute that the bill submitted by TMT was complete. Rather, Carrier asserts that it required additional documentation to make a medical necessity determination. If a carrier requires additional documentation not required by Division rules for a complete bill, the rules provide a method for requesting that documentation. The carrier must submit a request for additional documentation:

> (1) in writing;
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> (2) specific to the bill or the bill's related episode of care;
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> (3) describing with specificity the clinical and other information to be included in the response;
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> (4) that is relevant and necessary for the resolution of the bill;
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> (5) that is for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
>
> (6) that indicates the specific reason for which the insurance carrier is requesting the information; and
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> (7) that includes a copy of the medical bill for which the insurance carrier is requesting the additional documentation.[34]

If a carrier makes such a request, the provider is required to comply with it. Contrary to Carrier's argument, the onus was on Carrier to request supplemental documentation in addition

[32] 28 TAC § 133.210(b). Rule 133.210(c) also requires supporting documentation in addition to what is required for a complete bill in certain circumstances, none of which apply here.

[33] 28 TAC §133.200.

[34] 28 TAC § 133.210(d).

to what was required for a complete bill if Carrier determined such documentation was needed to make a medical necessity determination.

This interpretation is also consistent with a memorandum issued on March 26, 2008, by the Division, entitled "Improper Denials Based on Lack of Documentation."[35] In that memorandum, the Division addressed complaints regarding improper denials by carriers based on inadequate documentation and admonished, "In accordance with the Texas Labor Code, insurance carriers shall not deny payment for services based on the failure to provide documentation unless the [Texas Administrative Code] provisions specifically require documentation to be submitted with the medical bill for the services rendered; or, the health care provider has failed to respond to an insurance carrier's request for documentation submitted in accordance with 28 TAC § 133.210(d)."

In conclusion, the only relevant issues in this case were whether the amount of the fee billed by TMT was fair and reasonable and whether it met the reimbursement guidelines for clinical laboratory services, neither of which were disputed by Carrier.[36] In order to prevail in this case, Carrier was required to submit evidence of what a proper reimbursement amount should be for the services in issue. Carrier failed to do so. Therefore, Carrier failed to meet the burden of proof relevant to a medical fee dispute and the ALJ finds the amount of reimbursement ordered by MDR appropriate. Carrier is ordered to reimburse TMT the amount of $319.43 for the services in dispute in this case. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

[35] TMT Closing Argument Brief, Attachment B at 1.

[36] 28 TAC § 134.203.

## IV. FINDINGS OF FACT

1. On September 10, 2012, Texas Medical Toxicology (TMT) performed medical services consisting of laboratory quantitative urine drug testing (the services) for an injured worker (claimant).

2. Texas Mutual Insurance Company (Carrier) was the responsible workers' compensation insurer for the claimant.

3. On December 7, 2012, TMT billed Carrier for the services. Included with the bill was the laboratory test report and the physician's order.

4. On January 15, 2013, Carrier issued an explanation of benefits (EOB) to TMT, with ANSI nonpayment codes, denying payment.

5. On February 21, 2013, TMT submitted a request for reconsideration to Carrier, explaining that TMT was "performing urine drug confirmation tests for multiple drugs using Liquid Chromatography/Mass Spectrometry to provide quantitative confirmation of drugs." In addition, TMT stated that the documents submitted indicated each separate drug being tested for.

6. On April 1, 2013, Carrier issued a second EOB, with the same nonpayment codes as on the January 15 EOB.

7. TMT timely filed a request for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

8. On September 3, 2013, the Division issued its Medical Fee Dispute Resolution Findings and Decision (MDR Decision), ordering Carrier to pay an additional $319.43, plus applicable accrued interest.

9. Carrier timely requested a hearing before the State Office of Administrative Hearings (SOAH) to contest the MDR Decision.

10. A Notice of Hearing informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

11. On March 24, 2014, a hearing convened before Administrative Law Judge Joanne Summerhays at SOAH's facilities in Austin, Texas. TMT was represented by attorney Laura O'Hara. Carrier was represented by attorney Timothy P. Riley. The record closed on April 28, 2014, following the filing of post-hearing briefs.

12. Carrier presented no evidence disproving that the amount of the fee billed by TMT was fair and reasonable and met the reimbursement guidelines for clinical laboratory services.

## V. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Lab. Code § 413.031; Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided. Tex. Gov't Code §§ 2001.051, 2001.052.

3. If an insurance carrier disputes the amount of payment (medical fee dispute) or the health care provider's entitlement to payment (medical necessity dispute), the insurance carrier shall send to the health care provider a report (EOB) that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. Tex. Lab. Act §408.027(d).

4. A medical fee dispute is a dispute over the amount of payment for services that have been determined to be medically necessary. 28 Tex. Admin. Code § 133.305(a)(5).

5. The services provided to the claimant were covered by a fee guideline issued by the Division. 28 Tex. Admin. Code § 134.203.

6. Carrier had the burden of proving by a preponderance of the evidence that the amount of TMT's bill was inappropriate under the fee guideline. 1 Tex. Admin. Code § 155.427.

7. Because Carrier failed to carry its burden of proof, the ALJ finds that Carrier has not shown itself entitled to relief from the MDR Decision; therefore, it is required to reimburse the additional amount of $319.43 plus interest.

## ORDER

**IT IS ORDERED** that Carrier pay TMT the additional sum of $319.43, plus accrued interest, in addition to the reimbursement already paid for the services in issue.

## NONPREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the nonprevailing party to reimburse DWC for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312,

Carrier is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

**SIGNED May 14, 2014**.

JOANNE SUMMERHAYS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS