

TEXAS WORKERS' COMPENSATION **Education Conference**



When a Medical Bill is Denied for Compensability, Extent of Injury, and Liability: A Health Care Provider's Perspective

Workers' Compensation Education Conference
2016



Learning Objectives

- I. How to find out if a benefit dispute already exists, the first step in avoiding medical bill denials for compensability, extent of injury, or liability.

- II. Be able to determine when a medical bill is denied for compensability, extent of injury or liability reasons.

Learning Objectives

- III. Understand how benefit disputes are resolved.
- IV. How to participate in the Benefit Dispute Resolution process.
- V. Be able to apply best practices in resolving benefit disputes as described by a Texas health care provider.

Objective I

How to find out if a benefit dispute already exists, the first step in avoiding medical bill payment denials for compensability, extent of injury, or liability.

Texas Labor Code (Labor Code)

§401.011. General Definitions

"Compensable injury" means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.

"Course and scope of employment" means an activity ... that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer... on the premises of the employer or at other locations.



Prohibition Against Billing the Injured Employee

In accordance with Labor Code §413.042:

- A health care provider may not bill an injured employee unless the injury is finally adjudicated as not compensable.
- Identifying a workers' compensation patient early is key to avoiding this administrative violation.

Effective Intake Questions

- Is the treatment you are seeking due to a work-related injury?
 - This question should be asked of all patients.
 - Ask this question more than once and expressed differently.
 - » (ex: Where did this injury occur? Were you working at the time of the injury?)

Effective Intake Questions

- Do you have any outstanding benefit disputes on compensability and/or extent of injury and/or liability?
 - Insurance carrier is required to send notice of any benefit disputes directly to the injured employee.

Effective Intake Questions

- Ask the referring health care provider if they are aware of any outstanding disputes on compensability or extent of injury.
 - They may have knowledge due to denied medical bills, or
 - the referral provider may have participated in the Benefit Dispute Resolution process already.

Effective Intake Questions

- Ask the insurance carrier's adjuster if there are any outstanding benefit disputes on the claim (injury) also.
 - Insurance carrier is not required to send notice of benefit dispute to the health care provider, except:
 - network claims, and
 - preauthorization process.

Notice of Denial

28 TAC CHAPTER 124 CARRIERS: REQUIRED NOTICES AND MODE OF PAYMENT

Upon receipt of notice of injury, the carrier begins investigation of:

- compensability of the injury,
- the carrier's liability for the injury, and
- the accrual of benefits.

Plain Language Notice (PLN) 01 - *Notice of Denial of
Compensability/Liability and Refusal to Pay*

**carrier is not required to send a PLN01 to the health care provider except for
network claims*

Notice of Denial

28 TAC CHAPTER 124 CARRIERS: REQUIRED NOTICES AND MODE OF PAYMENT

PLN01 filed between 15th and 60th day after receipt of written notice of injury.

- Carrier is liable and must pay all medical services provided **prior** to filing the PLN01.

Notice of Disputed Issue(s)

28 TAC CHAPTER 124 CARRIERS: REQUIRED NOTICES AND MODE OF PAYMENT

Upon receipt of medical bill

- Carrier believes treatment(s) or service(s) are not related to the compensable injury.

PLN11 - Notice of Disputed Issue(s) and Refusal to Pay Benefits (extent of injury/relatedness dispute.)

**Carrier is not required to send the PLN11 to the health care provider.*

Notice of Disputed Issue(s)

28 TAC CHAPTER 124 CARRIERS: REQUIRED NOTICES AND MODE OF PAYMENT

Notice of dispute of extent of injury (PLN11) filed not later than the earlier of:

- date the carrier denied the medical bill; or
- due date for the carrier to pay or deny the medical bill.

Notice to Network Provider

Texas Insurance Code (TIC)

CHAPTER 1305. WORKERS' COMPENSATION HEALTH CARE NETWORKS

TIC §1305.153 Provider Reimbursement:

- An insurance carrier shall notify in writing a network provider if the carrier contests the compensability of the injury for which the provider provides health care services.

Notice to Network Provider

TIC CHAPTER 1305. WORKERS' COMPENSATION HEALTH CARE NETWORKS

Prior to providing written notification to network health care provider:

- carrier may not deny payment for medically necessary health care services based on compensability; and
- carrier is liable for up to a maximum of \$7,000 for medically necessary health care services provided prior to notification.

Objective II

Be able to determine when payment of a medical bill is denied for compensability, extent of injury and/or liability reasons.

Claim Adjustment Reason Codes Associated with Compensability, Extent of Injury, and Liability Explanation of Benefits Denials

219 - Based on extent of injury.

P2 - Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

P4 - Workers' compensation claim adjudicated as non-compensable.

P6 - Based on entitlement to benefits.

P8 - Claim is under investigation.

28 TAC

§133.240 Medical Payments and Denials

If the insurance carrier reduces or denies payment for compensability of the injury or liability for the injury, or for a condition for which the health care was not related to the injury, the insurance carrier must have previously filed or must concurrently file a:

PLN01 - Notice of Denial of Compensability/Liability and Refusal to Pay, or

PLN11- Notice of Disputed Issue(s) and Refusal to Pay Benefits.

Request for Reconsideration after Denial

28 TAC §133.250

If the health care 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 its action.

Objective III

**Understand how benefit disputes
are resolved.**

Benefit Dispute Resolution Steps for Final Adjudication

- Benefit Review Conference (BRC)
- Arbitration
- Contested Case Hearing (CCH)
- Appeals Panel
- Judicial Review

Benefit Review Conference (BRC)

*First level in DWC benefit dispute resolution

Dispute can be resolved at BRC by:

- signed written agreement between injured employee, their representative, the insurance carrier representative and the DWC benefit review officer (DWC Form-024, *Benefit Dispute Agreement*).

Benefit Review Conference (BRC)

When the dispute is not resolved at BRC a

- 2nd BRC set, or
- CCH scheduled.

When the dispute is not resolved at second BRC

- CCH scheduled.

Contested Case Hearing (CCH)

***Second level in DWC benefit dispute resolution**

A formal hearing conducted by a DWC hearing officer

- Makes a decision about the disputed issue(s).
- Issues a written decision and order.
- Appeals must be filed within 15 days.
- Parties shall comply with decision, even if appealed.

Appeals Panel

***Final level in DWC benefit dispute resolution**

– DWC Appeals Panel

If pursued further, a judicial review in a court of law is next.

DWC Online Resources for BRC and CCH

- Benefit Review Conference

<http://www.tdi.texas.gov//wc/employee/dispute.html#brc>

- Contested Case Hearing

<http://www.tdi.texas.gov//wc/employee/dispute.html#cch>

Objective IV

**How to participate in the Benefit Dispute
Resolution process.**

Steps to Participate

1. Attempt to resolve the dispute informally with parties.
2. Establish subclaimant status with the local DWC field office.
3. Participate in Benefit Dispute Resolution to obtain final adjudication:
 - BRC (agreement) or
 - CCH (decision and order).

Subclaimant Status: Establishment, Rights, and Procedures

28 TAC §140.6 Subclaimant Status: Establishment, Rights, and Procedures

- A subclaimant may file and pursue a claim for reimbursement of a benefit that has been provided to an injured employee, and is entitled to appropriate dispute resolution.

Subclaimant Status: Establishment, Rights, and Procedures

A subclaimant may participate in the dispute resolution process without the participation of the injured employee if:

- There is no prior written agreement between the injured employee and the workers' compensation insurance carrier or no final decision by the DWC on the issue in dispute.

Subclaimant Status: Establishment, Rights, and Procedures

- The workers' compensation insurance carrier has denied the entitlement to benefits under the Texas Workers' Compensation Act and Division rules.
- The injured employee is not pursuing dispute resolution to establish the injured employee's entitlement to benefits with reasonable diligence.

Subclaimant Status: Establishment, Rights, and Procedures

A subclaimant must provide the injured employee with written notice of:

- subclaimant's intent to pursue a claim for reimbursement of a benefit,
- warning that a decision rendered may be binding against the injured employee, and
- contact information for the Office of the Injured Employee Counsel.

Office of Injured Employee Counsel

- Injured employee(s) pursuing dispute resolution may receive ombudsman assistance by calling:

1-866-EZE-OIEC (1-866-393-6432)

www.oiec.texas.gov

Benefit Review Conference (BRC)

28 TAC §141.1 Requesting and Setting a BRC

- Prior to requesting a BRC, a disputing party must notify the other party or parties of the nature of the dispute and attempt to resolve the dispute.

Benefit Review Conference (BRC)

Requesting a BRC

Submit a written request to the local DWC field office
DWC Form-045, *Request for a BRC*

http://www.tdi.texas.gov/wc/idr/brc_info_sc.html

Benefit Review Conference (BRC)

Include with the DWC Form-045:

- Medical bills and related EOB(s) that indicate the carrier denied for compensability, extent of injury or relatedness.
- Documentation of efforts to resolve the disputed issues, for example, correspondence, emails, facsimiles, records of telephone contacts, or summaries of meetings or telephone conversations.
(28 TAC §141.1)

Benefit Review Conference (BRC)

Include with the DWC Form-045:

- Signature by the requesting party attesting that reasonable efforts have been made to resolve the disputed issue prior to requesting the BRC.
- Documentation of a written attempt to contact the injured employee, 28 TAC §140.6 (c)(2)(D).
- Send a copy to opposing party or parties.

Benefit Review Conference (BRC)

After receipt of the request, DWC will:

- Determine if request is complete.
- If incomplete, DWC will notify parties and state reasons why the BRC is denied.
- If complete, a BRC will be set within 40 days, (if DWC decides an expedited BRC is needed, 20 days).

Benefit Review Conference (BRC)

How to prepare for a BRC

- DWC Hearings will send a “Set Notice” to the health care provider, providing instructions.
- Have a copy of all information sent to request the BRC.
- Know the maximum allowable reimbursement (MAR) value related to your medical bill.
- Know the diagnoses codes and descriptions for the denied medical bill(s).

Benefit Review Conference (BRC)

How to prepare for a BRC

- Be available to participate in person or by phone if approved by benefit review officer.
- Provide any causation analysis statements/letters from the health care provider, or the health care provider can participate in the BRC.

Benefit Review Conference (BRC)

What to expect at a BRC

- Injured employee and their representative, the carrier's representative, other subclaimants, and the employer may all be present, along with the DWC Hearings benefit review officer (BRO).
- BRCs are set for 45 minutes to an hour.

Benefit Review Conference (BRC)

What to expect at a BRC

- Parties reach an agreement.
- If an agreement is not reached, you may request a CCH, but it is at the BRO's discretion.
- There is a limit of 2 BRCs prior to a CCH.

Contested Case Hearing (CCH)

CCH without the injured employee's participation, the subclaimant must show:

- Subclaimant provided written notice to the injured employee,
- it has contacted the injured employee and the injured employee is not pursuing the dispute with reasonable diligence, or
- it has been unable to contact the injured employee.

Contested Case Hearing (CCH)

- A CCH decision not appealed to the Appeals Panel becomes final on the 16th day after the date received from the hearings division.
- Parties shall comply with a final decision and order within 20 days of the date it becomes final.
- Payment of medical benefits pursuant to a decision shall be made in accordance with Chapters 408 and 413 of the Texas Labor Code.

Objective V

Be able to apply best practices in resolving benefit disputes as described by a Texas health care provider with practical experience.