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| **___,** | ' | **BEFORE THE STATE OFFICE** |
| **Petitioner** | ' | |
| | ' | |
| **V.** | ' | **OF** |
| | ' | |
| **LIBERTY MUTUAL FIRE** | ' | |
| **INSURANCE COMPANY,** | ' | **ADMINISTRATIVE HEARINGS** |
| **Respondent** | ' | |

## DECISION AND ORDER

This case is an appeal by an individual claimant, ___ (APetitioner@), from a decision by the Medical Review Division (AMRD@) of the Texas Workers= Compensation Commission (ACommission@) in a medical fee dispute. The MRD found that the insurer, Liberty Mutual Fire Insurance Company (ARespondent@), properly denied reimbursement for four medical office visits provided to the Petitioner, based upon lack of evidence that Respondent ever received the requisite submission of medical bills for such services.

Petitioner challenged the decision on grounds that failures in documentation cited by the MRD were the fault of the treating physician and the insurer B for which Petitioner, as the injured patient, should not be penalized.

This decision agrees with that of the MRD, finding that reimbursement of Petitioner for the disputed services should be denied.

## I. JURISDICTION AND VENUE

The Commission has jurisdiction over this matter pursuant to ' 413.031 of the Texas Workers= Compensation Act (Athe Act@), TEX. LABOR CODE ANN. ch. 401 *et seq.* The State Office of Administrative Hearings (ASOAH@) 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 and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction or venue.

## II. STATEMENT OF THE CASE

The hearing in this docket was convened on June 17, 2004, at SOAH facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (AALJ@) Mike Rogan presided. Petitioner appeared by telephone and was assisted by both his wife and by Luz Loza of the Ombudsman's Office at the Commission. Respondent was represented by Charlotte Salter, Attorney. Both parties presented evidence and argument. The record remained open until July 8, 2004, to allow the parties to submit additional argument and briefing.[1]

[1] The staff of the Commission formally elected not to participate in this proceeding, although it filed a general AStatement of Matters Asserted@ with the notice of the hearing.

The record revealed that on ___, Petitioner suffered a compensable injury to the lower back, when he attempted to lift heavy furniture. He has suffered from chronic pain and has remained unable to work since the injury, despite two surgeries, injections, and extended physical therapy. Generally, he visits his treating physician monthly to obtain prescriptions for pain medication. His condition has not changed perceptibly over the past two years.

Sometime in early 2003, Petitioner's physician informed him that the insurer for Petitioner's employer (*i.e.*, Respondent) had refused to reimburse the physician for further office visits in Petitioner's case and that Petitioner would therefore have to begin paying the physician directly for services. Accordingly, Petitioner paid the physician for four office visits, from March 14 through June 6, 2003. Petitioner himself subsequently sought reimbursement for these services from Respondent, which was refused. Petitioner then sought medical dispute resolution through the Commission.

The Commission's MRD reviewed the matter and issued a decision on January 20, 2004, which stated the following rationale:

> According to rule 133.307(f)(3), the requestor shall submit convincing evidence that the carrier received the requestor's request for reimbursement. The case file does not contain any evidence of a submission of medical bills to the respondent. Therefore, based solely on this evidence reimbursement is not recommended.

Petitioner then made a timely request for review of the MRD decision before SOAH.

## III. THE PARTIES' EVIDENCE AND ARGUMENTS

### A. Petitioner

According to Petitioner, Respondent received actual notice that the disputed medical services were performed, even if the provider never submitted any formal bills for the services. The record indicates that, sometime shortly after the last disputed office visit, Petitioner sent Respondent copies of receipts from the treating physician to Petitioner, reflecting Petitioner's payment for the disputed services. Based upon this evidence, Petitioner argues, Respondent should have either paid for the services or issued a formal explanation of benefits (AEOB@), showing when and why reimbursement was denied. Respondent's failure to do either of these things in this case constitutes a violation of 28 TEX. ADMIN CODE (ATAC@) ' 133.304(f) B for which Petitioner should not have to suffer the consequences. Rule 133.304(f) provides:

> The insurance carrier shall send a copy of the [EOB] to the injured employee at the same time it is sent to the sender of the bill if the insurance carrier has reduced or denied payment for a charge on the bill because the insurance carrier believes that treatment(s) and/or service(s) were : (1) unreasonable and unnecessary; (2) provided by a health care provider other than [specified eligible providers]; or (3) unrelated to the compensable injury. . .

To support his position, Petitioner asserts that SOAH has consistently held B in situations where the provider did not receive an EOB B that other kinds of correspondence or evidence can suffice to show the basis for an insurer's denial of reimbursement.[2]

Petitioner also submitted in evidence a letter from his treating physician B dated February 1, 2003, and addressed ATo Whom It May Concern@ B which included the following statements:

> [___] is a patient who has: 1. Chronic Intractable pain. He is getting medically appropriate treatment with OxyContin 160 mg three times a day. . . . There are no over-the-counter substitutes for OxyContin, and it is my understanding the insurance company is going to suddenly terminate his narcotic therapy.
>
> Given the above facts, the patient may well most likely have sudden withdrawal and resulting complications, including cardiac arrhythmia, respiratory compromise, hypertension and substantial increase of his morbidity and mortality.

**B. Respondent**

Respondent argues that without the submission of a medical bill in substantial compliance with 28 TAC ' 133.1(3), none of the duties or obligations imposed upon insurers by the Act and implementing regulations attach. In this case, no evidence indicates that Respondent ever received a proper bill for the services in dispute. What Respondent did receive B *i.e.*, general receipts allegedly reflecting payment for the relevant treatment B did not provide actual notice of the specific medical services performed or of the associated billing. Rather, Respondent contends, Petitioner's documentation provided, at most, Asome evidence that the Claimant had voluntarily paid for some health care services.@ Respondent concludes that no obligation exists, under Commission rules, for Respondent to take further action after receiving such general and incomplete documentation.

In addition, Respondent reasons that Adirect and voluntary payment by a claimant to a health care provider arguably raises the presumption that the health care provider did not intend to provide health care to a claimant for compensable injuries.@ Citing ' 413.042 of the Act and 28 TAC ' 134.801(h), Respondent notes that a provider is prohibited from directly charging an injured worker for treatment of a compensable injury, and instead *must* bill the insurance carrier. In the instant case, Respondent thus concludes, Athe provider either believed that he was not treating a compensable injury or he was guilty of an administrative violation.@ Evidence produced by Petitioner did not adequately address either possibility.

A letter dated July 21, 2003, from Respondent's Medical Dispute Unit to the Commission's MRD (although formally placed in evidence by Petitioner) included the following statements about Petitioner's case:

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[2] Petitioner=s AClosing Statement@ cited a number of SOAH decisions for this proposition, but only one of them B SOAH Docket No. 453-02-1881.M4 (Oct. 10, 2002, ALJ Newchurch) B actually is relevant to the asserted principle.

> Enclosed please find a copy of an IME [Aindependent medical evaluation@] report from Dr. Aaron Combs, MD stating that medications such as OxyContin and Zoloft are not medically reasonable and necessary . . . This report also states that the claimant should be weaned from narcotic medications, which can be accomplished over a 2-4 week weaning period.
>
> The claimant reached Maximum Medical Improvement on 11/13/98 but continued to treat with [the treating physician] to obtain medications. [The physician] did receive a copy of the IME report and it appears that he has now decided to treate the claimant on a cash only basis, to avoid non payment of the Workers Compensation claims.
>
> Please note that Liberty Mutual did not receive any bills to review and all the claimant submitted was copies of receipts from a receipt book.

## IV. ANALYSIS

Petitioner bears the burden of proving that the factual basis or analytical rationale for the MRD's decision in this case was invalid. In the ALJ's view, he has not discharged that burden.

The ALJ is unable to perceive how Respondent has violated 28 TAC ' 133.304(f), as Petitioner asserts. That rule requires an insurance carrier to send a copy of an EOB to an injured employee under three categories of circumstances B none of which has been raised as a direct issue in this case. More fundamentally, the rule requires the sending of such a copy only when the carrier provides the EOB to the Asender of the bill@ who has initiated the pertinent claim-resolution process (as defined in other provisions of 28 TAC ch. 133). In this case, neither the requestor (Petitioner), the provider, nor anyone else has submitted such a bill to the carrier. Thus, the contingency that would trigger Respondent's obligation to provide Petitioner an EOB under 28 TAC ' 133.304(f) has simply never occurred.

Indeed, that same contingency B the submission to Respondent of a complete medical bill conforming with Commission requirements, including those in 28 TAC ' 133.1(3)[3] B appears to be one of the most fundamental prerequisites for initiating the Commission's standard claim-processing and resolution process. This is true not only because it is a procedural step that is pervasively integrated into the resolution process,[4] but also for practical reasons of claim-evaluation; as noted in Respondent's closing argument, Awithout medical bills as defined by the Commission, the Carrier would be unable to determine the specific type of health care provided to the Claimant and whether the services were related to a compensable injury, both of which are prerequisites to payment.@

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[3] Under this rule, the requirements for a Acomplete medical bill@ include submission on a Commission-prescribed form and use of correct billing codes for the services provided B neither of which was satisfied by the documentation submitted by Petitioner.

[4] 28 TAC '' 133.304(a), (b), and (c), among numerous other provisions in that chapter of the rules, reflect that submission of a proper bill to the carrier is the departure-point for the claim-resolution process.

The MRD reasonably found, therefore, that the lack of evidence for any submission of medical bills in this case represented a fundamental inadequacy in the pursuit of Petitioner's claim. Appreciating the MRD's rationale for this decision may be impeded by the sometimes inconsistent phraseology of the Commission's rules. (Notably, the rules suggest in several places that bills will always be submitted by health care *providers*, yet they allow for other entities, including injured employees, to initiate the claim process that begins with the submission of a proper bill.) Still, the overall logic of the rules appears to require a claimant such as Petitioner to provide the insurer with the specific type of billing prescribed by regulations. Section 133.307(f) of the rules requires an injured employee to file a request for medical dispute resolution Ain the form, format, and manner prescribed by the commission,@ which apparently incorporates the requirement for submitting a proper bill. Also, as noted above, ' 133.304(f) pointedly refers to the Asender of the bill@ in addressing a carrier's responsibilities upon initiation of a claim, which contrasts with numerous other rules provisions that seem to identify billing exclusively with the relevant provider.

In the ALJ's view, the MRD has accepted the valid principle that a carrier, in evaluating a claim under the Act from *any* source, should have access to the systematic, detailed information provided by billing that complies with Commission regulations. A reasonable corollary would be that a claimant such as Petitioner B an injured employee B should have the same opportunity that a provider typically has to communicate with the carrier and to correct any deficiencies in billing documentation that are pointed out by the carrier before the carrier makes an initial decision on reimbursement. In this case, however, Petitioner has offered no substantial evidence addressing what opportunity he had to bring the documentation of his claim into compliance with regulatory standards prior to initiating the medical dispute resolution process with the Commission.

## V. CONCLUSION

The ALJ finds that, under the record provided in this case, Petitioner has not demonstrated his satisfaction of basic procedural prerequisites for seeking reimbursement of the medical services at issue. Reimbursement for these services should be denied, accordingly, as initially determined by the MRD.

## VI. FINDINGS OF FACT

1. On ___, ___ (APetitioner@) suffered an injury to his lower back that was a compensable injury under the Texas Worker's Compensation Act (Athe Act@), TEX. LABOR CODE ANN. ' 401.001 *et seq*.

2. Petitioner has suffered from chronic pain and has remained unable to work since the injury, despite two surgeries, injections, and extended physical therapy.

3. Sometime in early 2003, Petitioner's physician informed him that the insurer for Petitioner's employer, Liberty Mutual Fire Insurance Co. ("Respondent") had refused to reimburse the physician for further office visits in Petitioner's case and that Petitioner would therefore have to begin paying the physician directly for services. Accordingly, Petitioner paid the physician for four office visits, from March 14 through June 6, 2003.

4. Petitioner himself sought reimbursement for services noted in Finding of Fact No. 3 from Respondent.

5. The Respondent denied the requested reimbursement.

6. Petitioner made a request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested reimbursement.

7. The Commission's Medical Review Division ("MRD") issued a decision (in dispute resolution docket No. M4___) on January 20, 2004, concluding that the case file contained no evidence of submission of medical bills to Respondent and thus that Petitioner had failed to satisfy 28 TEX. ADMIN CODE ("TAC") § 133.307(f)(3), requiring the requestor in a medical dispute resolution to submit "convincing evidence that the carrier received the requestor's request for reimbursement." The MRD accordingly recommended no reimbursement for the services in dispute.

9. Petitioner requested in timely manner a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the MRD decision regarding reimbursement.

10. The Commission mailed notice of the hearing's setting to the parties at their addresses on February 24, 2004. The hearing was subsequently continued to a later date, with proper notice to the parties.

11. A hearing in this matter was convened before SOAH on June 17, 2004. Petitioner appeared telephonically and received assistance from his wife and frp, staff of the Commission's Office of Ombudsman. Respondent appeared and was represented by counsel. The record in the case closed on July 8, 2004, after the parties submitted written closing argument.

12. In submitting the claim for reimbursement noted in Finding of Fact No. 4, Petitioner provided only general receipts from his physician, relating to the dates of service at issue, but no actual medical bills reflecting CPT codes or other ancillary documentation.

## VII. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction related to this matter pursuant to § 413.031 of the Act.

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 and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TAC § 133.305(g) and §§ 148.001-148.028.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T

CODE ANN. §§ 2001.051 and 2001.052.

5. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC ' §148.21(h).

6. Based upon the foregoing Findings of Fact, Petitioner failed to comply with requirements of 28 TAC ch. 133 that actual medical bills with specified content be submitted to an insurance carrier in initiating a claim for the corresponding medical services.

7. Based upon the foregoing Findings of Fact, Petitioner failed to comply with 28 TAC §133.307(f)(3), requiring the requestor in a medical dispute resolution to submit "convincing evidence" that the carrier received the requestor's reimbursement request, which would include actual medical bills with specified content relating to the disputed services.

8. Based upon the foregoing Findings of Fact and Conclusions of Law, the findings and decision in this matter of the MRD, issued on January 20, 2004, were correct; Petitioner's request of reimbursement for services noted in Findings of Fact No. 3 should be denied.

## ORDER

**IT IS THEREFORE, ORDERED** that the appeal of ___, seeking reimbursement for medical office visits from March 14 through June 6, 2003, be denied, in accordance with the findings and decision of the Medical Review Division issued in this matter on January 20, 2004, which concluded that ___ failed to comply with 28 TAC §133.307(f)(3), requiring the requestor in a medical dispute resolution to submit "convincing evidence" that the carrier received the requestor's reimbursement request in proper form.

**SIGNED July 13, 2004.**

**MIKE ROGAN**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**