SOAH DOCKET NO. 453-05-2040.M5
TWCC MR NO. M5-04-2323-01

ZURICH AMERICAN INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
CENTRAL DALLAS REHABILITATION, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Zurich American Insurance Company (Carrier) requested a hearing to contest a Medical Review Division (MRD) Decision ordering Carrier to reimburse Central Dallas Rehabilitation (Provider) for disputed work hardening and related services. The MRD decision was based in part on an independent review organization (IRO) determination, issued on behalf of the Texas Workers' Compensation Commission (Commission),[1] concluding that the disputed services were medically necessary. The undersigned Administrative Law Judge (ALJ) concludes that Carrier should pay for the disputed services.

I. PROCEDURAL HISTORY

A hearing convened in this case on July 18, 2005, before ALJ Ami L. Larson at the State Office of Administrative Hearings (SOAH), Austin, Texas. There were no objections to notice or jurisdiction. Carrier appeared through counsel Steven M. Tipton, who was present in person at the hearing. Provider was represented attorney Scott C. Hilliard, who appeared by telephone. The record was left open until September 6, 2005, for the filing of post-hearing written closing arguments.

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of Workers' Compensation at the Texas Department of Insurance.

II. DISCUSSION

A. Factual Background

The Claimant injured his left shoulder, low back, and right inguinal area during a workplace accident that occurred on___. He continued to work after the accident, but ceased working as of April 10, 2003, because of his injuries and ongoing pain.

Claimant received extensive treatment for his injuries, including X-rays, over-the-counter and prescription medication, MRI, EMG studies, physical therapy, chiropractic care, injection therapy, surgical repair of his inguinal hernia, rotator cuff surgery, and a work hardening program from September 30, 2003, through December 9, 2003. The work hardening program and related services are the only items being disputed in this case. Carrier denied payment for multiple services consisting of work hardening and associated office visits and conferences.

Carrier submitted an explanation of benefits (EOB) for services provided on September 29 and 30, 2003, indicating that those services were denied based on code "U". The "U" code stands for unnecessary treatment without peer review and is used when a carrier denies payment because it deems the treatment or services provided to be medically unreasonable and/or unnecessary and that judgment is not based on a peer review. The corresponding explanation provided by carrier for these dates of service stated merely, "Denied per adjuster. Current treatment is not reasonable or necessary."[2]

With respect to services provided from October 1 through October 16,[3] 2003, Carrier submitted EOB forms denying those services based on code "E", which refers to entitlement of benefits and is used when a carrier disputes liability for a claim or compensability of the injury and the issue has not been finally

[2] Provider's Exhibit 2, page 46.

[3] The only EOB regarding services on October 16, 2003, was submitted with respect to an office visit. No EOB was submitted by Carrier regarding the work hardening program itself provided on that date.

adjudicated. The explanation of this code stated, “Denied - ongoing treatment is not reasonable or necessary.”[4]

No EOBs were submitted to support Carrier’s denial of work hardening services from October 16 through November 7, 2003.[5] For the work hardening and related office visits provided from November 11 through December 9, 2003, Carrier submitted EOBs based on denial code “U” with an explanation stating, “Denied - current treatment is not reasonable or necessary.”[6]

B. Legal Standards

Injured employees have a right to necessary health care under TEX. LAB. CODE ANN. " 408.021 and 401.011. Section 408.021(a) provides, “An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.” Section 401.011(19) of the Labor Code provides that health care includes "all reasonable and necessary medical . . . services."

[4] Provider’s Exhibit 2, pages 50 and 51.

[5] Carrier did submit an EOB denying a November 7, 2003, Functional Capacity Evaluation (FCE) based on code “U” with a corresponding explanation of “Denied - current treatment is not reasonable or necessary.” The Medical Dispute Resolution Findings and Decision incorrectly states that no EOB was submitted for the November 7, 2003, FCE, however Respondent’s Exhibit 2, page 64 contains this document. Provider billed Carrier for an additional FCE conducted on December 4, 2003, for which no EOB was submitted by Carrier. Provider, on the record at the hearing, waived reimbursement in the amount of $738.80 for these FCEs, since it appeared that neither was addressed by the IRO or MRD decision.

[6] Provider’s Exhibit 2, pages 66, 73, 76, 81, and 84.

The law requires that when an insurance carrier denies reimbursement to a Provider for services rendered, it must explain why by using the proper payment exception code(s) as well as providing an explanation sufficient to allow the Provider to understand the reason(s) for the insurance carrier's action(s).[7] The carrier has 45 days after its receipt of a medical bill to respond and provide the proper explanation of benefits.[8]

As the appellant in this case, Carrier had the burden of proof.[9]

C. Carrier's Evidence and Argument

Carrier submitted a written closing argument, but offered no documentary exhibits or witness testimony. Carrier argued that none of the services for which it denied payment were medically necessary and, therefore, Provider should not be reimbursed for those services.

Carrier asserted that even though it denied some of those services based on code "E", which does not itself relate to medical necessity, it was or should have been clear that medical necessity was at issue for those services because of Carrier's explanation "ongoing treatment is not reasonable or necessary."

Carrier further argued that even if it failed to properly raise the issue of medical necessity for some of the denied services, those services should not be reimbursed since the Commission is responsible for ensuring compliance with the law and ordering payment only for medically necessary services whether or not Carrier raises the issue of medical necessity. Essentially, Carrier argues that medical necessity is always an issue and that Carrier cannot be deemed to have waived its right to argue lack of medical necessity without a clear statutory dictate to the contrary.

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[7] TEX. LABOR CODE ANN. § 408.027(d) and 28 TEX. ADMIN. CODE (TAC)§ 133.304(c).

[8] 28 TEX. ADMIN. CODE § 133.304.

[9] 1 TAC§155.41(b); 28 TAC § 148(h).

D. Provider's Evidence and Argument

Provider submitted two documentary exhibits and a written closing argument.

Provider argues that, for those services denied by use of code "E", Carrier failed to properly raise the issue of medical necessity by using a code unrelated to medical necessity. With respect to those services denied by use of code "U", Provider argues that Carrier failed to sufficiently explain the rationale for its denial on general medical necessity grounds. Provider takes the position that, therefore, Carrier has waived its right to show on appeal that any of the denied services were medically unnecessary because it failed to comply with the Commission's rules requiring a Carrier who denies payment for services to submit properly coded EOBs along with an adequate explanation of the Carrier's rationale for refusing payment for all services denied.

III. ANALYSIS

For the reasons cited below, the ALJ finds that Carrier failed to meet its burden to show that the MRD decision is incorrect and, therefore, orders Carrier to reimburse Provider for the disputed services.

Although Carrier's arguments about why it should not be deemed to have waived its right to argue medical necessity where it was not initially raised by the proper payment exception code are thoughtful and not without logic, recent SOAH precedent holds that, in general, a Carrier cannot substitute a reason or explanation for denying payment for services that it did not assert before the MRD when it denied the claims initially. Although exceptional circumstances may justify a departure from this precedent, the general rule furthers the interests of fairness and justice and should be followed.

In this case, there are three categories of services for which Carrier has denied payment: those for which Carrier submitted no EOBs, those for which Carrier cited code "E" as the basis for its denial, and those for which Carrier cited code "U" as the basis for its denial.

A. **No EOBs**

With respect to the disputed services for which no EOBs were provided by Carrier,[10] the MRD substantiated that claims had in fact been submitted by Provider and ordered reimbursement pursuant to the Medicare Fee Schedule. The ALJ agrees that Carrier should reimburse Provider for these services at the rates ordered by the MRD since there was no basis for denial of payment in the record.

B. Exception Code "E"

For the services Carrier denied based on code "AE",[11] the MRD ordered reimbursement after noting that the parties initially disputed, but ultimately agreed, that the lumbar spine was included as part of Claimant's compensable injury.[12]

The "E" code, as noted earlier, does not concern the issue of medical necessity, but rather disputes compensability of the injury upon which the denied services were based. Carrier argues that even though the denial code itself may not raise the issue of medical necessity, the explanation that accompanied that code made it clear that medical necessity was at issue.

The undersigned ALJ does not agree with Carrier's argument. The Commission's rules clearly and unambiguously require Carrier to provide both the proper payment exception code and an explanation sufficient to allow Provider to understand the rationale underlying the exception code cited.[13] The explanation is intended to provide more specific information about the exception code, not a completely different rationale from the code itself.

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[10] Work hardening and related office visits from October 16 through November 7, 2003(with the exception of an October 16, 2003, office visit for which an EOB was submitted).

[11] Work hardening and related office visits provided from October 1 through October 15, 2003, and an office visit on October 16, 2003.

[12] Provider's Exhibit 2, page 9.

[13] TEX. LAB. CODE § 408.027(d) and 28 TAC § 133.304(c).

In this case, the explanation provided by Carrier makes sense in conjunction with the "E" code since, if the lumbar spine injury were not compensable, any services provided to treat the lumbar spine would not be medically necessary with respect to the compensable injury, which is the only injury at issue in a workers'compensation case.

Once the issue of compensability was resolved by agreement of the parties, however, it does not mean that Carrier's explanation automatically serves to then raise a new denial based on medical necessity grounds without a revised EOB and corresponding "U" or "V" denial code.[14]

Accordingly, the ALJ agrees with the MRD decision ordering reimbursement for these services according to the Medicare Fee Schedule.[15]

C. Exception Code "U"

Provider asserts that Carrier should not be allowed to argue about the medical necessity of those services denied based on code "U"[16] since, even though the "U" code does raise the issue of medical necessity, Carrier failed to provide a sufficiently detailed explanation of its rationale in conjunction with the denial code it cited.

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[14] The situation may be different in a case where there is evidence of a genuine typographical error in coding or inadvertent omission of the intended code by Carrier. For example, had the "E" code in this case not been factually appropriate to the situation *and* had it been accompanied by a more detailed explanation making it clear that medical necessity was intended as a reason for denial with a specific explanation of Carrier's rationale for its view that the disputed services were not medically necessary, perhaps Carrier's argument would be stronger. That is certainly not the situation in this case, however, since the only explanation provided by Carrier was brief and conclusory and the "E" code was applicable to the facts of the case at the time it was raised.

[15] It is unclear whether the IRO decision addressed the medical necessity of the services denied based on code "E". That decision merely found the "work hardening/conditioning and office visits for dates in dispute 09/30/03 through 12/09/03" were medically necessary and should be reimbursed. Since the services coded "E" fell in the middle of the dates reviewed by the IRO, it can be argued that the IRO included the "E" coded dates of service in its determination of medical necessity. However, the MRD decision reviewed disputed services that were not addressed by the IRO and included the denials based on exception code "E". In either case, those services should be reimbursed by Carrier since the compensability issue was resolved and Carrier did not deny payment on general medical necessity grounds.

[16] Work hardening and related services provided from November 7 through December 9, 2003.

The undersigned ALJ agrees with Provider that Carrier did not provide a sufficient explanation of its denial code pursuant to the Commission's rules. However, under the circumstances of this case, the ALJ does not feel that Carrier's technical violation should preclude it from being able to argue the issue of medical necessity.

The purpose of the denial code and accompanying explanation is to put the Provider on notice as to why the Carrier is denying payment for specific services. Unlike the situation described above, where Carrier denied payment based on code "E", which does not implicate medical necessity, the Provider was on notice that the services coded "U" were being denied on medical necessity grounds. There is no evidence that Provider was unclear about the reasons for Carrier's denial as to these services. If Provider had been uncertain as to Carrier's underlying rationale, it could have sought clarification from Carrier and there is no evidence that Provider did so or attempted to do so.

Moreover, although the rule requires an explanation beyond what Carrier provided, it does not specify the remedy for a violation. In this case, because Provider was on notice that medical necessity was at issue and there is no evidence that Provider was unclear about the basis for the denial or was harmed by the lack of sufficient explanation, the undersigned ALJ does not believe it is appropriate to preclude Carrier from attempting to show that the services denied pursuant to code "U" were not medically necessary. The ALJ, therefore, considered Carrier's evidence and arguments regarding the medical necessity of the disputed services provided from November 11 through December 9, 2003.

Carrier argues that the work hardening services provided during this disputed period were not medically necessary primarily because the services actually provided to Claimant did not qualify as a work hardening program for a variety of reasons according to Commission requirements for such a program.

For example, Carrier argued that the work hardening program provided to Claimant did not consist of the required team members, and was not individualized to Claimant as required. Carrier's arguments in this regard, however, relate not to the issue of medical necessity, but rather to the sufficiency of the documentation submitted by Provider to show that the services billed are actually the services provided. If this is the basis upon which Carrier denied payment for the work hardening services, it should have used exception code "N" to put Provider on notice that more information was necessary to support its claim regarding the work hardening program for which it sought reimbursement. Further, Carrier should have provided an explanation to accompany that code that made clear to Provider what the perceived deficiencies were so that Provider could supplement the missing information and avoid further dispute if possible.

The issue of medical necessity raised by the "U" code looks at whether or not the treatment provided was medically necessary to treat Claimant's compensable injury according to the standards set forth in the Labor Code.[17] In this case, the IRO decision found work hardening to be medically necessary based on a review of the documentation regarding Claimant's treatment history as well as two related articles cited in the IRO decision.

Although Carrier argues that there was no identifiable psychosocial or behavioral problem that would have required a work hardening program versus a work conditioning program, Carrier had the burden of proof and did not present any evidence to show what level of psychosocial or behavioral problem, if any, is required in order for a work hardening program to be an appropriate treatment option.[18]

[17] TEX. LABOR CODE ANN. §§ 408.021 and 401.011.

[18] Appendix A of Carrier's Closing Argument includes a work hardening program description which lists behavioral and psychological issues among those treated by a work hardening, or Comprehensive Occupational Rehabilitation Program, but does not specify the degree to which these issues must be present or how they should manifest themselves in order for a Claimant to be an appropriate candidate for such a program.

The evidence shows that Claimant underwent a number of single disciplinary treatment modalities and was still unable to return to work six months after his work-related accident. Additionally, not only did Claimant's treating doctor refer him to a work hardening program, but also the required medical examination (completed by Dr. Agana at the request of the Commission), recommended that Claimant complete a work hardening program.[19] Although Dr. Agana does not specifically note in his report that Claimant suffered from any psychological or behavioral issues, without any evidence to the contrary the ALJ assumes that Dr. Agana was familiar with the admission criteria for work hardening and he recommended Claimant for that program because he was an appropriate candidate pursuant to relevant eligibility criteria.

The ALJ concludes that Carrier failed to meet its burden to show that the work hardening program and related office visits from October 16 through November 7, 2003 were not medically necessary and, therefore, Carrier should reimburse Provider for those services.

IV. FINDINGS OF FACT

1. Claimant injured his left shoulder, low back, and right inguinal area during a workplace accident that occurred on___.

2. Prior to being referred to a work hardening program, Claimant received extensive treatment for his injuries, including X-rays, over-the-counter and prescription medication, MRI, EMG studies, physical therapy, chiropractic care, injection therapy, surgical repair of his inguinal hernia, and rotator cuff surgery.

3. Claimant was referred to a work hardening program by his treating doctor.

4. A required medical examination completed by Dr. Agana at the request of the Texas Workers' Compensation Commission (Commission) also recommended that Claimant participate in a work hardening program.

5. Prior to being referred to work hardening, Claimant underwent various single disciplinary treatment modalities but was still unable to return to work six months after his work-related accident.

[19] Provider's Exhibit 2, page 21.

6. Claimant participated in a work hardening program and associated office visits from September 30, 2003, through December 9, 2003.

7. Zurich American Insurance Company (Carrier) denied payment for the work hardening services and associated office visits provided to Claimant.

8. Carrier submitted an explanation of benefits (EOB) for services provided on September 29 and 30, 2003, indicating that those services were denied based on code "U". The corresponding explanation provided by carrier for these dates of service stated merely, "Denied per adjuster. Current treatment is not reasonable or necessary."

9. With respect to services provided from October 1 through October 15, 2003, and for an office visit on October 16, 2003, Carrier submitted EOB forms denying those services based on code "E" and provided a corresponding explanation stating, "Denied - ongoing treatment is not reasonable or necessary."

10. Carrier did not submit EOBs regarding work hardening services provided from October 16 through November 7, 2003.

11. For the work hardening and associated office visits provided from November 11 through December 9, 2003, Carrier submitted EOBs based on denial code "U" with a corresponding explanation stating, "denied - current treatment is not reasonable or necessary."

V. CONCLUSIONS OF LAW

1. 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 TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.052.

3. Carrier had the burden of proving that the disputed the work hardening and office visits for dates of service from November 11, 2003, through December 9, 2003, were not medically necessary treatment for Claimant's compensable injuries. 1 TEX. ADMIN. CODE (TAC) § 155.41; 28 TAC § 148(h).

4. An employee who sustains a compensable injury has a right to all health care reasonably required by the nature of the injury and when needed. TEX. LAB. CODE §§ 408.021 and 401.011.

5. The law requires an insurance carrier who denies payment of a claim to explain its rationale by using the proper payment exception code(s) as well as providing an explanation sufficient to allow the Provider to understand the reason(s) for the insurance carrier's action. TEX. LABOR CODE ANN. §408.027(d) and 28 TAC § 133.304(c).

6. Carrier should reimburse Provider for the work hardening and associated office visits for dates of service from September 30, 2003, through December 9, 2003. TEX. LAB. CODE § 408.021.

7. Carrier waived its right to argue the medical necessity of any services for which it did not file an exception code of "U" or "V" before the Medical Review Division (MRD).

8. Carrier should reimburse Central Dallas Rehab (Provider) for all services for which no EOBs were submitted according to the Medicare Fee Schedule as ordered by MRD.

9. Carrier should reimburse Provider for all services for which payment was denied by use of code "E" according to the Medicare Fee Schedule as ordered by MRD.

10. Carrier failed to meet its burden of proof to show that the services for which payment was denied by use of code "U" were not medically necessary and, therefore, Carrier should reimburse Provider for all of those services as ordered by the MRD and IRO.

11. Carrier failed to provide sufficient explanations regarding its rationale for denying services based on the payment exception codes it cited.

12. Carrier should not reimburse Provider for the FCEs conducted on November 7, 2003, and December 4, 2003, since Provider waived reimbursement for those services.

ORDER

IT IS THEREFORE ORDERED that Zurich American Insurance Company pay Central Dallas Rehab for the disputed work hardening services and associated office visits for dates of service from September 30, 2003, through December 9, 2003.

SIGNED November 4, 2005.

AMI L. LARSON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS