DOCKET NO. 453-05-4790.M4
MR NO. M4-05-1146-01

NATIONAL UNION FIRE INSURANCE COMPANY, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
INTERIM HEALTHCARE SERVICES, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. Introduction

National Union Fire Insurance Company (Carrier) disputes the decision of the Texas Workers' Compensation Commission (Commission)/Medical Review Division (MRD) ordering Carrier to pay additional reimbursement for medical services provided to Claimant by Interim HealthCare Services (Provider) between January 31 and March 26, 2004. The disputed amount is $13,938.77. Carrier requested a contested-case hearing to challenge MRD's decision, but subsequently argued that the State Office of Administrative Hearings (SOAH) does not have jurisdiction to consider this matter. After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that SOAH does have jurisdiction to consider this matter, and that Carrier failed to prove by a preponderance of the evidence that Provider was not entitled to the complete reimbursement for the medical services provided by Provider to Claimant. Therefore, the ALJ denies Carrier's request to deny reimbursement.

II. Background

Claimant was injured at work on___, in an accident that rendered him a quadriplegic requiring around-the-clock medical care. At that time, Carrier used GAB, a case management company, as its agent to handle Claimant's case. In August 1992, Carrier, through GAB, agreed to pay Provider a negotiated hourly rate for home health care provided by Licensed Vocational Nurses (LVNs) and supervised by a Registered Nurse twenty-four-hours a day, seven days a week.

Periodically, Provider would notify GAB in writing of an increase in the negotiated rate. GAB indicated acceptance of the new negotiated rate by paying Provider at this new rate. Because it is a negotiated fee, Provider billed it under CPT Code 99199.[1] GAB promptly paid Provider (usually within 14 to 30 days of the invoice) because Provider is a small business and payment for the skilled care nurses accounted for a substantial amount of Provider's overhead.

The last adjustment to the negotiated amount was in June 2003. On May 9, 2003, Provider sent GAB a letter notifying GAB that the "new base rate" as of June 1, 2003, would be $35.50. GAB did not object to the rate increase and began paying Provider at this rate. In November 2003, AIG replaced GAB as the case management company handling Claimant's case for Carrier. Carrier did not notify Provider of the change of case manager prior to December 15, 2003.

At that time, Provider advised AIG in a letter of the negotiated rate it had with GAB and Carrier. AIG paid Provider the full negotiated rate ($35.50) for services provided through January 30, 2004. For services delivered in February and March, 2004, Carrier's explanation of benefits

[1] 28 TEX. ADMIN. CODE (TAC) § 134.202(d) provides:

> (d) In all cases, reimbursement shall be the least of the:
> (1) MAR amount as established by this rule;
> (2) health care provider's usual and customary charge; or,
> (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

(EOBs) and payments began trickling in months after Provider submitted the claims.[2] Throughout this time, Provider discussed with Carrier its need to be paid promptly and to determine if Carrier intended to renegotiate the billing rate. Carrier failed to respond, other than to say it would comply with the Commission's rules.

It was not until early March 2004, that AIG/Carrier notified Provider that it intended to take reductions of 30 to 40 percent from Provider's total billed amount. AIG/Carrier did not provide a sufficient explanation for these significant reductions other than to note on the EOBs that it was a bill review reduction and network reduction. While the EOBs failed to explain these reductions, Provider tried to secure this information from AIG. AIG gave Provider little meaningful information to justify the reductions, but told Provider if it was unsatisfied with the payment Provider should go directly to the Commission.

Because Provider could not continue to provide the medical services to Claimant at this reduced rate, Provider stopped caring for Claimant on March 27, 2004. According to Provider, the skilled care-takers providing Claimant's care were allowed to leave Provider's employment to work for Claimant. Consistent with AIG's instructions, Provider filed a medical dispute resolution request with the Commission. Carrier, through its attorney, received notice of the filing shortly thereafter, on October 19, 2004. Carrier did not object to Provider's request; instead Carrier participated in the medical dispute resolution process.

MRD issued its decision on February 17, 2005. The following week, Carrier's counsel filed a request for a hearing before SOAH. Notice of the hearing before SOAH was provided both parties on March 15, 2005. Carrier first asserted the argument that Provider's failure to file a written request for reconsideration barred Provider's right to request dispute resolution when Carrier filed a motion for summary disposition on May 16, 2005.

[2]Ex. 1 at 161-163.

JURISDICTION

Carrier argues that because Provider failed to file a written request for reconsideration prior to filing a request for medical fee dispute with MRD, neither MRD or SOAH has jurisdiction to consider this matter. Carrier maintains that the Commission's rules regarding the payment process, and, ultimately, the appeal process, must be strictly construed.

Although this matter was presented as a medical fee dispute, it is unique in its facts and in its application of the Commission's rules. Carrier does not dispute the need for Provider's services, that Provider provided all the services billed, or that Provider received full payment based on the negotiated rate several months prior to Carrier imposing reductions against Provider's negotiated rate. Nor did Carrier offer any evidence explaining the reasonableness of the reductions.

More importantly, Carrier did not provide evidence controverting Mr. Marek's testimony that Carrier told him to go directly to the Commission if Provider was dissatisfied with Carrier's determination. Indeed, Carrier candidly admits that if the matter is dismissed, it will object to Provider's right to refile its claim because the deadline to appeal a disputed claim has passed.[3]

Carrier appears to be asking the ALJ to consider one requirement within the Commission's rules in a vacuum. The ALJ is disinclined to do so, and does not believe the Commission's rules envisioned such manipulation of its rules to thwart the purpose of the rules-ensuring a fair and reasonable process by which payments are to be made and medical fee disputes are to be processed.

[3] 28 TAC§ 133.307(d).

The medical fee payment process requires a carrier to take final action on a medical bill no later than 45 days after receipt of the bill.[4] Final action is defined in the Commission's Rules as:

> "Reimbursement that meets the standards set out in § 413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or (A) the maximum allowable reimbursement, when one has been established in an applicable Commission fee guideline, (B) the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no maximum allowable reimbursement amount, or (C) a negotiated contract amount."[5]

At the time a carrier makes payment to a provider, the carrier must include on the EOB the correct exception code and "shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)."[6] Generic statements are not sufficient.

If the provider is dissatisfied with the carrier's final action on a bill, the sender may request that the carrier reconsider its action.[7] If the provider is still dissatisfied after the carrier takes final action on the request for reconsideration, the provider may request medical dispute resolution as set out in 28 TAC § 133.307.

When Provider called Carrier numerous times to try to secure full payment, Carrier told Provider that if Provider did not agree with Carrier's decision, it should go directly to the Commission. Although Provider filed a request for medical dispute resolution without first filing a request for reconsideration, Carrier did not object at that time, supporting Provider's position that Carrier had instructed Provider to go directly to the Commission with this dispute. Even after Carrier hired John Fundis, an attorney, and Mr. Fundis questioned MRD about Provider's failure to

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[4]28 TAC § 133.304.

[5]28 TAC § 133.1(8) emphasis added.

[6]28 TAC § 133.304(c).

[7]28 TAC§133.304(k).

file a request for reconsideration, Carrier did not notify Provider of its concern and did not object. Instead, Carrier filed an appeal and asked for a contested case hearing before SOAH.

Carrier filed its request to have the matter referred to SOAH on February 24, 2005, and notice of the hearing was issued on March 15, 2005. Carrier did not file a motion for summary disposition until May 16, 2005. This was the first time Carrier had notified Provider that it objected to Provider's failure to file a request for reconsideration (contradicting Carrier's previous instructions to Provider). Conveniently, by this time the deadline for Provider to refile its appeal with the Commission had passed.

The ALJ finds Carrier's objection to be untimely and contrary to Carrier's instructions to Provider. Provider detrimentally relied on Carrier's instructions to by-pass the process and to go directly to the Commission. Carrier's conduct supports Mr. Marek's testimony that Carrier told him to go directly to the Commission because despite filing a request for medical dispute without a request for reconsideration, Carrier did not ask that MRD dismiss the matter. Therefore, the ALJ finds that Carrier failed to timely raise this objection, waived its right to raise this issue by its conduct, and is estopped to raising this defense now. Furthermore, AIG's instructions to Provider provided good cause for Provider's failure to file a written request for reconsideration.[8]

In addition, Carrier is asking for selective enforcement of the Commission's rules. While Carrier insists the Commission's rules be strictly applied to Provider, Carrier does not strictly comply with these rules. Carrier's explanation of benefits is devoid of any meaningful explanation for why Carrier was reducing the payments. The Carrier did not provide a sufficient explanation for these deductions in the EOBs. Instead, when Provider tried to discuss the reductions with Carrier, Carrier instructed Provider to go to the Commission if it was dissatisfied with Carrier's payment. Carrier also failed to provide Provider with the EOBs or payment in the time frame required by the Commission's rules. Such a manipulation of the rules creates an unanticipated and unfair result. For

[8]*See* SOAH Docket No. 453-05-2073.M2, *Texas Mutual Insurance Company v. Shahid Reshid, M.D.*

these reasons, the ALJ finds SOAH has jurisdiction over this matter and denies Carrier's motion to dismiss.

IV. Discussion

Carrier failed to show how it arrived at the reductions Carrier took from the amounts owed Provider. Instead, the evidence shows that Provider had a negotiated fee agreement with Carrier to pay Provider $35.50 an hour, that Provider delivered the home health care services as agreed, and that Provider is entitled to full payment. Accordingly, the ALJ concludes that Provider properly billed for the home health services provided to Claimant between January 31 and March 26, 2004, and should recover the full amount billed, plus interest.

V. Findings of Fact

1. On___, the Claimant sustained a work-related injury that rendered him a quadriplegic as a result of his work activities (compensable injury).

2. National Union Fire Insurance Company (Carrier) is the carrier of workers' compensation insurance covering Claimant's compensable injury.

3. Claimant's case was managed for Carrier by GAB, a case management company.

4. In August 1992, Carrier, through GAB, agreed to pay Interim HeathCare Services (Provider) a negotiated hourly rate for skilled home health care twenty-four hours a day, seven days a week.

5. Through the years, Provider notified GAB in writing of any increases in this negotiated rate, which GAB accepted and paid.

6. On May 9, 2003, Provider submitted a written request to GAB to increase the negotiated rate for the home health care provided Claimant from $33.75 per hour to $35.50 per hour.

7. GAB accepted the increase in the negotiated rate and paid 100 percent of the new amount when Provider submitted its bills for payment.

8. AIG replaced GAB as Carrier's case management company in November 2003.

9. Provider was not advised that Carrier had changed its case management company to AIG until mid-December 2003.

10. On December 15, 2003, Provider notified AIG in writing of the terms of its agreement with GAB, including the fact that the negotiated hourly rate was $35.50.

11. AIG did not notify Provider that Carrier would not honor the agreed negotiated rate for Provider's services.

12. Carrier, through AIG, paid the full amount of the negotiated hourly rate for services delivered by Provider to Claimant through January 30, 2004.

13. Provider was not notified until it received the explanation of benefits (EOB) and payment from Carrier in mid-March 2004, that Carrier was taking a reduction of 30 to 40 percent for unexplained bill review reductions and network reductions.

14. For the services rendered by Provider in February and through March 19, 2004, AIG failed to pay Provider's bills within 45 days of the receipt of these bills.

15. For the services rendered by Provider in February and through March 19, 2004, AIG failed to send Provider sufficient explanation to allow the sender to understand the reason(s) for Carrier's reductions.

16. AIG did not renegotiate with Provider the negotiated rate agreed to by Carrier and Provider in June 2003.

17. Provider furnished medical services to the Claimant on the following dates for the following amounts under CPT Code 99199 and was paid the amount reflected by Carrier as shown below:

DOS	Billed	Paid
1/31/04 to 2/6/04	$6,106.00	$3,633.07
2/7/04 to 2/13/04	$6,354.50	$3780.93
2/14/04 to 2/20/04	$6,106.00	$3,633.07
2/24/04 to 2/27/04	$6,106.00	$3,633.07
2/28/04 to 3/05/04	$7,052.00	$4,195.94
3/06/04 to 3/12/04	$7,052.00	$5,416.84
3/13/04 to 3/19/04	$7,052.00	$4,195.94
3/20/04 to 3/26/04	$7,052.00	$4,195.94

18. Provider asked AIG to reconsider the reimbursement and to pay the full amount billed, not the discounted amounts Carrier paid for the provided medical services.

19. AIG, as Carrier's agent, provided no reasonable explanation for the discounts it took from Provider's requests for reimbursement.

20. AIG, as Carrier's agent, told Provider that if Provider did not agree with Carrier's reductions, Provider should go directly to the Texas Workers' Compensation Commission (Commission).

21. Carrier's conduct waived any right to object to Provider's failure to file a request for reconsideration having stated to Provider that no further reconsideration would be conducted on these claims.

22. On October 14, 2005, Provider requested medical dispute resolution by the Commission's Medical Review Division (MRD).

23. Shortly thereafter, Carrier received notice that Provider had filed a request for medical dispute resolution with MRD.

24. Carrier participated in the medical dispute resolution process before MRD.

25. Carrier did not object to Provider's request for dispute resolution for Provider's failure to file a written request for reconsideration.

26. MRD issued an order on February 17, 2005, granting the additional reimbursement requested by Provider for the services rendered to Claimant between January 31 and March 26, 2004, in the amount of $13,938.77.

27. On February 24, 2005, Carrier requested a contest case hearing before an Administrative Law Judge (ALJ) with the State Office of Administrative Hearings (SOAH), and the matter was referred to SOAH on March 11, 2005.

28. Notice of the hearing was sent to the parties on March 15, 2005.

29. The notice contained a statement of the time, place, and nature of the hearing, and the legal authority and jurisdiction under which the hearing was to be held; a reference to the sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

30. On October 17, 2005, ALJ Catherine C. Egan convened a hearing in this case. John Fundis, Attorney, appeared for Carrier. Jim Marek, Provider's Executive Vice-President, appeared

on behalf of Provider. The record remained opened for the filing of briefs until October 31, 2005, at which time the record closed.

31. Provider provided medical services to Claimant at a reasonable negotiated base rate of $35.50 from January 31 to March 26, 2004.

VI. 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. LABOR CODE ANN. (Labor Code) §§ 402.073(b) and 413.031(k) (West 2005),

2. TEX. GOV'T CODE ANN. (Gov't Code) ch. 2003 (West 2005), and Acts 2005, 79th Leg., ch. 265, § 8.013, eff. Sept. 1, 2005.

3. The hearing was conducted pursuant to the Administrative Procedure Act, Gov't Code ch. 2001 and 28 TEX. ADMIN. CODE (TAC) ch. 148.

4. The request for a hearing was timely made pursuant to 28 TAC § 148.3.

5. Adequate and timely notice of the hearing was provided in accordance with Gov't Code §§ 2001.051 and 2001.052.

6. Based on the above Findings of Fact and Gov't Code § 2003.050 (a) and (b), 1 TAC § 155.41(b) (2005), and 28 TAC § 148.14 (2005), Carrier has the burden of proof in this case.

7. 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 that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. Labor Code § 408.021(a).

8. Carrier failed to reimburse Provider the negotiated contract amount of $35.50 per hour for medical care provided by Provider to Claimant in compliance with 28 TAC § 133.1(8) and 28 TAC § 133.304.

9. Carrier did not justify the discounts and charges taken against Provider's requests for payment in compliance with 28 TAC § 133.304(c).

10. Based on the above Findings of Fact and Conclusions of Law, Carrier's request to deny the additional reimbursement to Provider should be denied.

ORDER

IT IS ORDERED that the National Union Fire Insurance Company is required to reimburse Interim Healthcare Company $13,938.77, plus all accrued interest, for the home health care services (CPT Code 99199) provided to Claimant from January 31, 2004, to March 26, 2004.

Signed December 30, 2005.

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CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS