SOAH DOCKET NO. 453-05-9682.M5
TWCC MR NO. M5-05-2389-01

LUMBERMENS UNDERWRITING ALLIANCE,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	**OF**
V.	§	
	§	
MAIN REHAB & DIAGNOSTIC,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

This is a dispute over reimbursement for services performed for an injury suffered by Claimant while in the course and scope of his employment. The Administrative Law Judge (ALJ) concludes that the therapeutic services should be reimbursed, as Lumbermen's Underwriting Alliance (Carrier and Petitioner) failed to state denial codes or rationales on its Explanation of Benefit forms (EOBs) that complied with the Texas Labor Code (Labor Code) or the Texas Administrative Code.

I. FACTUAL AND PROCEDURAL HISTORY

Due to the predicate issue raised by Main Rehab and Diagnostic (Provider and Respondent), the merits of the medical necessity dispute are not reached and will only be briefly discussed herein. While the Provider prevails in this matter due to Carrier's failure to use the proper denial codes in its EOBs, the ALJ is aware that the parties have obviously litigated this as a matter of medical necessity. The ALJ's decision is not merely based on whether appropriate denial codes were used to give Provider notice that this was a medical necessity claim, but also the Carrier's failure to state clear rationales for the denials. Finally, had this decision progressed beyond the Carrier's EOBs, the ALJ would have ruled that the Carrier had the burden of disproving medical necessity, that the Carrier failed to meet that burden, and that the Provider stated a prima facie case of medical necessity.

Claimant suffered a work-related bilateral hernia on___, and underwent hernia repair surgery on February 4, 2004. On March 28, 2004, the Claimant visited a designated doctor who recommended physical therapy. On May 1, 2004, Claimant's physical therapy began at Provider's clinic, which concluded on May 20, 2004. On May 28, 2004, Provider placed Claimant at maximum medical improvement, with an impairment rating of 10% and a recommendation for the Claimant to return to work and resume his normal work duties. The disputed services were rendered from April

30, 2004, through May 28, 2004. The CPT codes in issue are 97110, 99203, 97150, 99212, 99211 and 99213. The amount in dispute is $3,117.91.

Claiming lack of medical necessity, Carrier denied reimbursement of Provider's treatment of Claimant except for one office visit on May 17, 2004, and the May 28, 2004 impairment rating. Provider filed a timely request for medical dispute resolution (MDR # M5-05-2389-01). The Independent Review Organization (IRO) determined that the disputed services were medically necessary.

Carrier filed a timely request for hearing before the State Office of Administrative Hearings (SOAH) on August 29, 2005. The Texas Worker's Compensation Commission (TWCC) issued a notice of hearing in this matter on November 15, 2005. A hearing was held on March 20, 2006, before Administrative Law Judge (ALJ) Travis Vickery. Provider and Carrier participated in the hearing, which was adjourned the same day. The parties submitted briefs and responses, and the record closed on July 24, 2006.

II. DISCUSSION

By stipulation of the parties, the only issue is whether the disputed services were medically necessary. On its EOBs, the Carrier used the following payment exception codes in denying reimbursement for the disputed services: F, GP, QU, R88, R95 Y, W1, W9 and V5. The Labor Code and the Texas Administrative Code require a carrier to deny services as medically unnecessary using payment exception codes of either U or V. The Carrier must also provide at least one rationale for each denial code.

The Carrier's EOBs are inadequate for two reasons: 1) the Carrier failed to use proper payment exception codes; and 2) the associated rationales are too cryptic to meet the requirements of Section 408.027(d) of the Labor Code or 28 TEX. ADMIN. CODE (TAC) § 133.304(c).[1] Only two of the Carrier's payment exception codes (QU and V5) even possess the proper letter associated with a medical necessity denial code (U or V). Yet, the rationales offered for those codes fail to explain reasons for denial:

QU Physician providing service in an Urban HPSA.

V5 Level of MMI for treating doc (mod to high 45).

[1] Since this dispute arose under 28 TAC §133.304 and not the new rules, the ALJ applies those coding provisions to this matter.

The Labor Code and the Administrative Code clearly require that within 45 days of its receipt of a provider's bill, a carrier must issue an EOB with a proper denial code that is sufficiently explained. Section 408.027(d) of the Labor Code states:

> 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 . . . (Emphasis added).

28 TAC § 133.304(a) states the deadline for a carrier to submit an EOB:

> . . . [A]n insurance carrier shall take final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill.

28 TAC §133.304(c) requires:

> At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier *shall* send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits *shall include the correct payment exception codes* required by the Commission's instructions, and *shall provide sufficient explanation* to allow the sender to understand the reason(s) for the insurance carrier's action(s). *A generic statement that simply states a conclusion such as not sufficiently documented or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section* . . . (Emphasis added).

Carrier's payment exception codes and rationales (for codes QU and V5) fall short of the requirements of the Labor Code or the Administrative Code. Both rationales are not only generic, but cryptic.

The requirement of a sufficient rationale serves a dual purpose: (1) that a carrier must conduct some form of investigation prior to denial of a claim - otherwise carriers could routinely deny claims without justification; and (2) to put the provider on notice of what was medically unnecessary about the services. A carrier's exception code and rationale shapes the course of litigation, and a clear rationale may lead to a resolution of the claim. Furthermore, it is a fundamental concept that litigation is not instituted without some form of factual investigation. The rule stated in 28 TAC § 133.304(c) does not allow for a "general denial" as it is known under the Texas Rules of Civil Procedure. Rather, it requires the opposite, albeit a minimal burden.

The Carrier argues that the codes and rationales are proprietary; that some of the same codes were used by the Provider; and that the codes are proper. Whether or not the Provider used the exception codes, they appeared on the Carrier's "Explanation of Review" forms, and the ALJ has applied the requirements of 28 TAC §133.304 to them. None of the codes are the simple U or V required under 28 TAC§133.304. Even assuming the appropriate exception codes had been used in the first place, unless the proprietary rationales are disclosed, it is impossible for the Provider to understand, or receive notice of why the services were deemed medically unnecessary. In any litigation, a party is entitled to understand the basis for a claim or defense and TWCC disputes are no different. Denial of reimbursement by reference to a proprietary and undisclosed code is the classic sword and shield. If the Carrier will not disclose the meanings of the proprietary codes, then it has failed to meet its burden to explain "the reasons for the reduction or denial of payment" or to "provide sufficient explanation to allow the [provider] to understand reason(s) for the insurance carrier's action(s)" as required by Labor Code Section 408.027(d) and 28 TAC § 133.304(c).

The Carrier's payment exception codes and rationales do not meet the Carrier's burden under the Labor Code or the Texas Administrative Code. The Carrier is barred from denying the Provider's claims based on lack of medical necessity. The ALJ finds that Provider is entitled to reimbursement of $3,117.91 for services billed under CPT Codes 97110, 99203, 97150, 99212, 99211 and 99213. The Carrier is ordered to reimburse the Provider for this amount. In support of this determination, the ALJ makes the following findings of fact and conclusions of law.

III. FINDINGS OF FACT

1. Claimant suffered a compensable, work-related bilateral hernia on___.

2. Texas Mutual Insurance Company (Carrier) is the provider of workers' compensation insurance covering Claimant for his compensable injury.

3. On February 4, 2004, Claimant underwent hernia repair surgery.

4. On March 28, 2004, Claimant's designated doctor recommended physical therapy.

5. On April 30, 2004, Claimant presented to Main Rehab & Diagnostic (Provider) for treatment.

6. Provider treated Claimant from April 30, 2004, through May 28, 2004 (Disputed Services).

7. Carrier declined to reimburse Provider for the Disputed Services.

8. Based on the Consolidated Table of Disputed Services, the total amount in dispute is $3,117.91. The Disputed Services involve CPT Codes 97110, 99203, 97150, 99212, 99211 and 99213.

9. Carrier denied reimbursement for the Disputed Services on the explanation of benefits (EOB) using the denial codes F, GP, QU, R88, R95 Y, W1, W9 and V5.

10. Carrier failed to use a proper denial code in denying the Disputed Services.

11. The rationale code "QU" is defined as "Physician providing service in an Urban HPSA..."

12. The rationale code "V5"is defined as "Level of MMI for treating doc (mod to high 45)."

13. Carrier failed to disclose to Provider the rationales for its denial on the grounds of medical necessity.

14. By failing to use the proper denial codes or to disclose to Provider its rationales for denial, Carrier's explanation was insufficient for Provider to understand Carrier's reason(s) for the denial of reimbursement of the disputed services.

15. Provider sought medical dispute resolution through the Texas Workers' Compensation Commission (Commission).

16. The matter was referred to an Independent Review Organization (IRO) designated by the Commission for the review process.

17. The IRO determined that the disputed services were medically necessary.

18. On August 29, 2005, Carrier requested a hearing before the State Office of Administrative Hearings (SOAH).

19. The Commission issued a notice of hearing in this matter on November 15, 2005.

20. The notice of hearing informed the parties that the hearing on the merits would be heard in Austin at SOAH on March 20, 2006.

21. The hearing convened on March 20, 2006, with ALJ Travis Vickery presiding. Provider appeared telephonically through its attorney, Scott Hilliard. Carrier appeared through its attorney, Steven M. Tipton. The hearing concluded and the record closed on July 24, 2006.

22. No parties objected to notice or jurisdiction.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically LABOR CODE ANN. §413.031(k) (2005), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE (TAC) ch. 148.

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

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Carrier had the burden of proof in this matter under a preponderance of the evidence standard. 28 TAC §§ 148.21(h), (i) and 1 TAC § 155.41(b).

6. When an insurance carrier makes or denies payment on a medical bill, the carrier must include on the EOB the correct payment exception code and a sufficient explanation to allow the provider to understand the reason for the carrier's action. 28 TAC § 133.304(c).

7. The correct payment exception codes for a carrier's denial of a medical bill from a provider for medical necessity are "U" or "V."

8. Carrier's explanation for denying reimbursement for the disputed services was legally inadequate as it failed to comply with the Commission's rules.

9. Because Carrier never denied reimbursement for the disputed services in compliance with the Commission's rules, Carrier is required to provide reimbursement.

10. Carrier is liable to Provider for a total reimbursement of $3,117.91 for services billed under CPT Codes 97110, 99203, 97150, 99212, 99211 and 99213.

ORDER

Lumbermen's Underwriting Alliance shall reimburse Main Rehab & Diagnostic a total of $3,117.91 for the services in dispute in this proceeding.

SIGNED September 12, 2006.

TRAVIS VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS