SOAH DOCKET NO. 454-08-2330.M4
TDI-DWC MFDR NO. M4-06-1219-01

INTEGRA SPECIALTY GROUP, P. A., Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
OLD REPUBLIC INSURANCE CO., Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Integra Specialty Group, P.A., (Provider) contested a medical fee dispute resolution decision issued by the Texas Department of Insurance-Division of Workers' Compensation (Division)[1] denying compensation to Provider for work hardening services on the basis that Provider failed to document that it had provided all of the interdisciplinary services comprising work hardening. At the time the Division's decision was issued, February 2, 2008, Provider claimed a total of $8,192.00 in reimbursement for work hardening.[2] Provider contended that Old Republic Insurance Co. (Carrier) had processed the bill incorrectly and that it was entitled to reimbursement based on evidence submitted at the hearing.

The hearing on this matter convened on July 23, 2008, in Austin, Texas, with Administrative Law Judge (ALJ) Cassandra J. Church presiding. The record closed that day. Attorney Scott D. Bouton represented Carrier and Dr. Spencer A. Sloane, D. C., represented Provider. Notice was proper and jurisdiction was established in this case.

The ALJ concludes that Provider failed to establish that the Division's medical fee dispute resolution decision was in error. The Division found correctly that Provider failed to provide sufficient documentation to justify reimbursement for a course of work hardening. The Carrier should not be required to make further reimbursement to Provider.

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[1] For clarity, the former Texas Workers' Compensation Commission will be referred to throughout as "Division," unless necessary to distinguish the current agency from the former.

[2] Other issues in the Division's decision were resolved before the hearing on the merits.

I. SUMMARY OF DISPUTE AND APPLICABLE LAW

A. Summary of the Case

The focus of the dispute was whether Provider's invoices to Carrier for the work hardening services constituted an incomplete billing or a complete billing that contained insufficient documentation. Essentially, Provider asserted that the absence of documents pertaining to all components of the interdisciplinary work hardening program rendered the billings incomplete. He asserted that Carrier had some duty, the extent of which was unspecified, to allow Provider an opportunity to complete its submission before it evaluated the substance of the invoices. For its part, Carrier contended that the completeness provisions in the rules pertained to ministerial issues such as correct bill coding, the existence of legible documentation, and complete information on the agency-approved form. Carrier contended that the administrative rule governing its initial review did not require a substantive review and also contended that it would be duplicative to treat an initial bill review and a retrospective review as the same thing.

B. Applicable Law

The administrative rules governing this case comprise the procedures applicable to services for 2004 dates of injury, a scheme different from the one currently in place. The definition of a "complete medical bill" appeared in Rule 133.1[3]:

> (a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:
>
> … (3) Complete medical bill – A medical bill that:
>
> (A) is submitted timely, in accordance with § 134.801 of this title (relating to Submitting Medical Bills for Payment):
>
> (B) is on the Commission-prescribed form and that includes the information required by the instructions for the form;

[3] 28 TEX. ADMIN. CODE § 133.1 (effective date July 15, 2000, for dates of services of July 15, 2000, or after).

(C) includes correct billing codes from Commission fee guidelines in effect on the date(s) of service (unless the bill is a request for reimbursement by a person other than a health care provider);

(D) contains supporting documentation when such documentation is specifically required by Commission rules or guidelines, unless the required documentation was previously provided to the insurance carrier or its agents; and

(E) includes the following legible supporting documentation, unless previously provided to the insurance carrier or its agents:

(i) *for the three highest level office visits, single and interdisciplinary program such as work conditioning programs, work hardening programs, and physical medicine treatment(s) and/or service(s): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or service(s), and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates,* ….[4] (Emphasis supplied.)

An insurance carrier was charged with reviewing bills submitted to it for completeness, as defined in Rule 133.1.[5] The only incomplete bills a carrier could return were duplicate bills. If the carrier detected other completeness issues, the carrier had to do one of the following:

(c)(2) Within seven days after the day it receives an incomplete medical bill, an insurance carrier shall:

(A) complete the bill by adding missing information already known to the insurance carrier;

(B) contact the sender by telephone, facsimile, or electronic transmission to obtain the information necessary to make the

[4] There are three additional classes of documentation described in Rule 131.1(a) (3) (E), none of which pertain to the treatment at issue.

[5] 28 TEX. ADMIN CODE § 133.300(c) (effective date July 15, 2000).

> bill complete and make the changes to the bill based on the information the sender provides; the insurance carrier shall document the name and telephone number of the person who supplied the information; or
>
> (C) if unable to complete the bill by adding missing information already known to the insurance carrier or contacting the sender, return the bill to the sender, in accordance with subsection (d) of this section.

Once a carrier received a complete bill, the carrier was permitted to retrospectively review that bill and pay for or deny payment for medical benefit in accordance with the Act[6], rules, the appropriate Division fee and treatment guidelines.[7] Once a carrier began its retrospective review of a complete bill, it had 45 days in which to make a final decision on whether to pay the bill.[8] In conducting a retrospective review under Rule 133.301 a carrier could consider the following elements: (1) compliance with fee guidelines; (2) compliance with treatment guidelines; (3) duplicate billing; (4) upcoding and/or unbundling; (5) billing for services not documented or substantiated; (7) accuracy of coding; (8) correct calculations; and (9) provision of unnecessary and/or unreasonable treatments or services.

In explaining the decisions reached in a retrospective review, a carrier had to inform a provider of the reasons why it denied the claim with sufficient clarity and detail to enable a provider to understand the reasons for the carrier's actions.[9] The vehicle for such explanation, the Explanation of Benefits (EOB), had to include the correct payment exception codes and comprise more than a generic statement that simply stated a conclusion, *i.e.*, "not sufficiently documented."

A party seeking fee dispute resolution was charged with making its request in the form and manner prescribed by the Division. The request had to be legible and include copies of all relevant medical bills, EOBs, peer reviews, and all medical records relevant to the dispute.[10] Specific

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[6] TEX. LAB. CODE ANN. Title 5, Workers' Compensation.
[7] 28 TEX. ADMIN CODE § 133.301(a) (effective date July 15, 2000).
[8] 28 TEX. ADMIN CODE § 133.304(a) – (f) (effective date July 15, 2000).
[9] 28 TEX. ADMIN CODE § 133.304(c) (effective date July 15, 2000).
[10] 28 TEX. ADMIN CODE § 133.305(c)(1)(A) – (J) (effective date July 15, 2000).

medical records that might be included with a party's dispute resolution request included a copy of medical records, clinical notes, diagnostic test results, treatment plans, and other documents relevant to the dispute and, for the fee portion, a table of disputed services.[11] The party also had to discuss how the documentation it submitted supported the requestor's position for each disputed issue.

II. HISTORY OF CASE

On ____, ____ (Claimant) injured his low back and suffered an inguinal hernia. Later that month, on ____, Claimant underwent an inguinal hernia repair. His low back injury was treated with medication. Claimant's symptoms persisted and on February 16, 2005, Claimant underwent a behavioral assessment for ongoing pain. Also during that period a functional capacity evaluation (FCE) was administered to Claimant in order to assess his level of disability.[12] Claimant was only able to perform sedentary work, but his job demand was for work at the heavy performance level. On February 24, 2005, based on these evaluations, Carrier preauthorized

Provider to conduct 10 sessions of work hardening for Claimant between February 24, 2005, and March 24, 2005. On April 13, 2005, Carrier preauthorized Provider to conduct 10 additional sessions of work hardening for Claimant between April 12, 2005, and May 18, 2005. Work hardening is a multidisciplinary, individualized course of treatment that addresses an injured worker's functional, physical, behavioral, and vocational needs. Physical medicine components included simulated work tasks and physical conditioning; mental health components included an initial mental health evaluation and group therapy.[13] Individual psychotherapy or counseling sessions were billed separately at that time.

Provider conducted the physical therapy, work conditioning, and behavioral retraining portions of the work hardening program (physical segment). The group counseling and psychotherapy (mental health segment) were administered by Susan Nohl, L.C.S.W. She was on

[11] 28 TEX. ADMIN CODE § 133.305(c)(1)(D) and (H).
[12] Provider Exhs. 1 and 5.
[13] *See generally*, Texas Workers' Compensation Commission *Medical Fee Guideline* (1996), pp. 36-39.

Provider's staff or was engaged by Provider to provide mental health services.[14] Ms. Nohl conducted three individual psychotherapy sessions with Claimant, and conducted seven group psychotherapy sessions in which Claimant was a participant.[15]

On various dates between March 3, 2005, and July 15, 2005, Provider submitted bills to Carrier for the physical segment of the work hardening treatment. However, Provider did not submit any progress notes, reports, or any other documentation describing the mental health segment. The invoices submitted by Provider were otherwise in correct form and contained the information required by Division statutes and rules to comprise a complete bill. At hearing, Dr. Sloane contended that the documents for the two aspects became separated in connection with Provider's attempts to file them under the then-new electronic bill filing system.

Carrier timely denied payment for all sessions of working hardening on the basis that Provider's documentation was insufficient to demonstrate that the service it had preauthorized had been provided.[16] Carrier did not request any additional information from Provider before it ruled on the claim. Carrier's witness, Angela Jones, a product support manager, stated that staff members who conducted initial bill reviews only determined whether some documentation was attached, but did not review its content, for services for which documentation was required. In the narrative portion of the denial for payment, Carrier used the following language, referencing the American National Standards Institute (ANSI)[17] Code in its EOB:

> 150—Pmt adj because the payer deems the info submitted does not support this level of svc. Payment denied or reduced as documentation does not support charges for an interdisciplinary program.

Provider timely requested a reconsideration of Carrier's denial. However, Provider also did not submit the mental health segment information with that request. Carrier denied reconsideration

[14] Provider Exh. 4.
[15] Provider Exh. 4. Topics included managing depression, stress, anger and grief, and also sleep hygiene.
[16] Carrier Exh. 2, pp. 3-102.
[17] ANSI Codes are standardized decision descriptors that carriers were required to use in their EOBs.

on the same grounds, insufficient documentation, and Provider timely requested fee dispute resolution before a Division's hearing officer. As noted above, the Division's Medical Fee Dispute Resolution Officer, Elizabeth Pickle, concurred with Carrier's handling of the claim and on February 21, 2008, upheld the Carrier's denial of reimbursement. Provider candidly acknowledged that he did not submit any documentation concerning the mental health segment of the treatment to the Division.

Provider timely requested a contested case hearing at the State Office of Administrative Hearings (SOAH). In the course of this hearing, Provider turned over to Carrier, for the first time, its records on the mental health segment of the work hardening treatment it conducted in early 2005.

There was apparently no dispute that the evidence of the mental health segment of the treatment would have been sufficient to support payment of the claim for work hardening had it been submitted to Carrier at the time of the claim.

III. DISCUSSION

Provider contended that it had submitted an incomplete bill, thus imposing a duty on Carrier to take the measures provided by the Division's rules in order to insure that the bill it reviews for payment is complete. Provider contended that because work hardening was a category of treatment for which documentation was required, Carrier had a duty during its initial bill review to determine whether it had received documentation for all phases of the preauthorized multi-disciplinary treatment.[18] Provider further contended that its documentation supported its provision of all the components of a work hardening program and that this documentation should be considered in the contested case hearing, notwithstanding Provider's failure to submit it to Carrier with its claim or during the fee dispute resolution process.

[18] 28 TEX. ADMIN CODE §§ 133.1(a)(3) and 133.300(c) and (d).

Carrier contended that Provider's bill was complete within the meaning of the rule, because it contained all the necessary administrative elements. The purpose of the initial bill review, it contended, was only to determine whether *any* documentation had been supplied to support the provision of services for which documentation was required, not to evaluate its substance. Carrier contended that its duty to examine the documentation for its substance did not arise until it elected to conduct a retrospective bill review. Carrier also contended that requiring a substantive review at the time the bill was first received was not reasonable given the required 7-day turnaround for ruling on completeness. Also, interpreting the rules to require a substantive review upon initial receipt and also upon conduct of a retrospective review would create duplication of effort and inefficiency.

Carrier further contended that none of the evidence submitted at the contested case hearing on the mental health segment of the treatment should be considered in rendering a decision because the issue at SOAH was review of the appropriateness of the Division's fee dispute resolution, not an independent inquiry into the sufficiency of the evidence to support payment.

The Division's rules support Carrier's interpretation of its duties in this case. The rules treated a carrier's obligations upon receipt of a bill and upon conduct of a retrospective review as separate functions, each with its own requirements and timetable. The rules relating to both were very specific in their requirements, but differ considerably. Rule 133.1 lists elements of required clerical content only whereas Rule 133.301 allows a carrier to delve into compliance with treatment guidelines, undocumented services, and the necessity of services provided. The required turnaround times of 7 days for an initial bill review and 45 days for a retrospective review mirror the difference between the two rules in complexity of required or allowed tasks. The ALJ is unable to perceive in Rule 133.1 any requirement either that a carrier was to review a bill for its substance in the first 7 days after it received it from a provider or that it send a provider a "heads up" that the quality of its documentation might result in a denial of payment.

In regard to the specific issue in this case, the Carrier's obligation in the first 7 days was to ascertain whether documentation was provided if required for a specified service. Provider's bill included documentation regarding work hardening, so was not incomplete within the meaning of that word set forth in Rule 133.1.

Provider's underlying premise was, in essence, that it was not fair to him to bar him from a second bite at the apple if the documentation originally submitted was incomplete through error or oversight. However, Provider's focus on the initial bill review seemingly ignores the subsequent opportunities that existed in the bill review process to give a provider a second, and even a third, bite at the apple. First, a provider was afforded the opportunity to seek reconsideration by the carrier of its initial denial of a claim. Second, a provider had access to a dispute resolution process at the Division to seek review of the carrier's decision. Although Provider availed himself of these opportunities, he seemed oblivious to the need to fully document the multi-disciplinary service that he had provided or to ascertain what may have gone awry with its submission.

Provider alleged, without foundation, that Carrier had not made its reasons for denial of the claim clear. The EOBs clearly state that the documentation did not support "this level of service" and that the payment should be denied because Provider did not support an interdisciplinary program. It is hard to imagine how much clearer Carrier could have been about its reason for denying payment within the limitations of the shorthand narrative used in an EOB. For whatever reason, Provider either discounted this statement or ignored it. It apparently never compared what it thought it sent in support of its claim with what Carrier or, later, the dispute resolution officer, actually had in hand. That omission was Provider's, not Carrier's.

On the basis of the above, the ALJ concludes that Provider failed to carry its burden of proof to show that the Division's dispute resolution decision was in error.

As to the issue of whether the evidence regarding the mental health segment of the work hardening program should be considered in the contested case hearing, the ALJ concludes that it should not. The historical practices in many cases heard before SOAH regarding the medical necessity for a procedure has been to admit evidence not considered by the Division's dispute resolution officer on the basis that the proceeding before SOAH is a new proceeding, not an appeal on the record made below. However, this case is in a somewhat different posture. This service was preauthorized so the issue of whether it was necessary to treat Claimant has already been resolved. It was then incumbent on Provider to demonstrate, in a timely manner, that it had provided the services approved. This Provider failed to do, although provided with three separate opportunities to do so. This case is not about evaluating the sufficiency of the evidence to support the claim, but rather, whether Provider timely presented it for review. This dispute on a procedural issue reached its appropriate point of repose when the dispute resolution decision was rendered.

In conclusion, the ALJ concludes that Provider failed to meet its burden of proof to show that Carrier wrongfully denied payment for work hardening services provided to Claimant between February through May 2005, and that the Division's dispute resolution decision issued on February 2, 2008, upholding Carrier was in error. The ALJ further concludes that the evidence of the mental health segment of the work hardening program should not be considered in this contested case due to the procedural nature of the contested issue. The effect of these conclusions is that the ALJ will order that Carrier has no obligation to pay the disputed claim.

IV. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his low back and suffered an inguinal hernia.

2. On ____, Claimant underwent surgery to repair the inguinal hernia.

3. Claimant's low back injury was treated with medication.

4. In February 2005, Claimant continued to report pain and was unable to perform his job duties at the required heavy demand level, but only at a sedentary level.

5. On February 24, 2005, Old Republic Insurance Co. (Carrier) preauthorized Integra Specialty Group, P. A. (Provider) to conduct 10 sessions of work hardening for Claimant between February 24, 2005, and March 24, 2005.

6. On April 13, 2005, Carrier preauthorized Provider to conduct 10 additional sessions of work hardening for Claimant between April 12, 2005, and May 18, 2005.

7. Provider conducted a work hardening treatment program for Claimant between February 25, 2005, and May 2, 2005, that included physical therapy, work conditioning activities, and behavioral retraining (physical segment) of work hardening treatment.

8. Provider also conducted or oversaw the provision of seven group and three individual psychotherapy sessions (mental health segment) for Claimant during the course of work hardening treatment.

9. On various dates between March 3, 2005, and May 11, 2005, Provider submitted bills to Carrier for the work hardening treatment (the bills).

10. Provider billed a total of $8,192.00 for the work hardening treatment performed over the four-month course of treatment.

11. The bills Provider submitted to Carrier did not include any documentation concerning the mental health segment of the work hardening treatment.

12. The bills that Provider submitted to Carrier included documentation concerning the physical segment of the work hardening treatment.

13. The bills that Provider submitted to Carrier were on the prescribed form, included all required information, included correct billing codes, and legible documentation of the physical segment of the work hardening treatment.

14. The billings for the work hardening treatment occurred during the period when the workers' compensation program was in transition to electronic submission of bills.

15. Carrier concluded that the bills submitted by Provider were complete and did not ask for additional information or return them to Provider for correction.

16. Carrier conducted a retrospective review of the bills.

17. In Explanation of Benefits (EOBs) returned to Provider, Carrier denied reimbursement for the work hardening treatment.

18. On all EOBs, Carrier denied reimbursement on the basis that Provider had not demonstrated that it had provided all the components of work hardening, an interdisciplinary program, so the bills did not support the level of service that had been preauthorized by Carrier.

19. On September 12, 2005, Provider requested reconsideration by Carrier of its denial of reimbursement.

20. Provider did not submit any documentation concerning the mental health component of the work hardening treatment with its request for reconsideration.

21. On reconsideration, Carrier continued to deny reimbursement on the basis that Provider had failed to establish that it provided an interdisciplinary service.

22. On October 7, 2005, Provider requested administrative review of its fee dispute.

23. Provider did not submit any documentation concerning the mental health component of the work hardening program with its request for administrative review of its fee dispute or at any time during the review conducted by the dispute resolution officer with the Texas Department of Insurance, Division of Workers' Compensation (Division).

24. On February 21, 2008, the Division's medical fee dispute resolution officer concluded that Carrier correctly denied reimbursement for work hardening as Provider had not supported the provision of an interdisciplinary program.

25. On March 18, 2008, Provider requested a contested case hearing and the case was referred to the State Office of Administrative Hearings (SOAH) on March 21, 2008.

26. On April 24, 2008, the Division issued a notice of administrative hearing for a contested case at SOAH.

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

28. ALJ Cassandra J. Church convened the hearing on July 23, 2008, in Austin, Texas, and the record closed that day.

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

2. The notice of the hearing issued by the Division conformed to the requirements of TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Provider had the burden of proving by the preponderance of the evidence that it was entitled to reimbursement for the disputed service, pursuant to 1 TEX. ADMIN CODE § 155.41(b) and 28 TEX. ADMIN CODE § 148.14(a).

4. Based on the above Findings of Fact, Provider failed to meet its burden of proof to show that Carrier violated provisions of 28 TEX. ADMIN. CODE Subchapter D in regard to the processing and auditing of medical bills.

5. Based on the above Findings of Fact and Conclusions of Law, Provider failed to meet its burden of proof to show that it is entitled to reimbursement for the disputed service.

ORDER

IT IS THEREFORE, ORDERED that Old Republic Insurance Co. is not required to reimburse Integra Specialty Group, P. A., for work hardening services performed between February 25, 2005, and May 2, 2005, for Claimant _____.

SIGNED September 11, 2008.

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CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS