SOAH DOCKET NO. 454-12-6138.M4
MFDR NO. _____

XL SPECIALTY INSURANCE CO., **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
PRIDE, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

XL Specialty Insurance Co. (Carrier) challenges the Medical Fee Dispute Findings and Decision of the Texas Department of Insurance, Division of Worker's Compensation (DWC), Medical Review Division (MRD), that ordered reimbursement of an additional $21,895.07 to PRIDE (Provider) for medical services provided to an injured worker (Claimant). The Administrative Law Judge (ALJ) concludes that MRD had and the State Office of Administrative Hearings (SOAH) has jurisdiction over this dispute and that Carrier's Motion to Dismiss should be denied. The ALJ further concludes that Carrier did not prove that Provider should not be reimbursed the additional $21,895.07. Therefore, the ALJ orders Carrier to pay Provider the additional $21,895.07, plus applicable interest.

I. PROCEDURAL HISTORY AND JURISDICTION

A. Procedural History

Claimant sustained a __ at work ____. After Claimant filed his claim, Carrier filed Plain Language Notice forms (PLN-11s) regarding the extent of the compensable injury. The first PLN-11, filed June 16, 2009, set out Carrier's contention that Claimant's compensable injury was limited to a low back sprain/strain and no other body parts. The second, filed November 10, 2009, reiterated that the compensable injury was limited to a lower back strain/sprain and specifically disputed

Claimant's entitlement to treatment for peroneal neuropathy and lumbar degenerative disease.[1]

Claimant received treatment in the form of epidural steroid injections and physical therapy. Although he was determined to be at maximum medical improvement by the designated doctor, he continued to complain of pain and restricted range of motion. Therefore, in February of 2010, Provider received preauthorization for chronic pain management program sessions, which Provider performed, along with other related services, between February 4 and April 21, 2010. Although the treatments were preauthorized as medically necessary, that preauthorization did not guarantee reimbursement.

Provider billed the services to Carrier. The only diagnosis code contained on the bills was "847.2 Lumbar Sprain and Strain." Carrier denied payment under various codes, including, on most of the bills, either "W12-Extent of injury. Not finally adjudicated" or "51- These are non-covered services because this is a pre-existing condition." The Explanations of Benefits (EOBs) did not specifically state that Carrier disputed that the treatments were related to the compensable injury. Carrier argued, however, that DWC has not specified a code for that particular reason for denial and has stated that Codes W12 and 51 should be used for that purpose.

A Benefit Review Conference (BRC) was held July 26, 2010; however, the parties were unable to reach an agreement. Therefore, a contested case hearing was held before a DWC Hearing Officer on September 23, 2010, pursuant to Texas Labor Code chapter 410. In a Decision and Order issued September 23, 2010, the Hearing Officer determined that the May 20, 2009, compensable injury did not extend to and include L2 and L5 disc protrusion and that Claimant had reached maximum medical improvement on October 6, 2009, with an impairment rating of 0%. That Decision and Order was affirmed by the Appeals Panel on December 21, 2010.[2] The contested case hearing did not address the issue of whether Provider's February 4 through April 21, 2010, treatments were related to the compensable injury.

[1] Carrier Ex. 2, pages 15-16.

[2] Carrier Ex. 2, pages 17-23.

On February 18, 2011, Provider filed its Medical Fee Dispute Resolution Request with MRD, requesting reimbursement of an additional $22,622.66. Carrier's response asked MRD to review the request under Texas Labor Code §§ 413.011 and 413.031(c) and related DWC rules and stated Carrier's belief that the treatments at issue were not related to lumbar strain/sprain. Carrier did not request dismissal of the request under 28 Texas Administrative Code (TAC) § 133.307(e)(3)(H).[3]

Before MRD considered the request, a second BRC was held July 5, 2011, to determine whether the lumbar strain/sprain was compensable. Following the BRC, on July 6, 2011, the parties reached a signed agreement "that the compensable injury of ___, extends to and includes a low back strain/sprain."[4] No other issues were addressed in that agreement. The agreement was signed by DWC on August 12, 2011.

MRD issued its Findings and Decision on April 23, 2012. MRD concluded there were no unresolved issues of extent of injury pertinent to the services in dispute. It denied reimbursement for CPT Codes 64483 and 77003 because they were related to the disc protrusions. It found that Provider sufficiently supported that the remaining services were for the compensable injury, and ordered Carrier to reimburse Provider $21,895.07.

Carrier filed a timely request for a hearing before SOAH. Provider did not file a request for a

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[3] The provisions of 28 TAC § 133.307(e)(3)(H) in effect at the time of the Findings and Decisions stated:

> (e) MDR Action. The Division will review the completed request and response to determine appropriate MDR action. . . .
>
> > (3) Dismissal. The Division may dismiss a request for medical fee dispute resolution if: . . .
> >
> > > (H) the carrier has raised a dispute pertaining to compensability; extent of injury; or liability for the claim. The Division shall notify the parties of the review requirement pursuant to § 124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals.

[4] Provider Ex. 2, page 1.

hearing.

Before the SOAH hearing, Carrier filed its Motion to Dismiss the proceeding. Carrier argued that the issue of whether the treatment was actually related to the compensable injury should have been resolved by the DWC Division of Hearings, pursuant to Texas Labor Code chapter 410, before any request for Medical Dispute Resolution was filed, and that MRD therefore had no jurisdiction to issue its Findings and Decision. Carrier asked SOAH to dismiss the case without prejudice so that the relatedness issue could be referred to and resolved by the DWC Division of Hearings under Texas Labor Code chapter 410.

The SOAH hearing was convened August 8, 2012, with both Carrier and Provider participating. The Motion to Dismiss was carried with the case. After the admission of documents and testimony, the hearing was adjourned.

The jurisdictional issues raised in Carrier's Motion to Dismiss in this case were also raised in other MRD cases before SOAH: Docket Nos. 454-12-5115.M4, 454-12-5870.M4, 454-12-6617.M4, 454-12-4228.M4, and 454-12-7138.M4. On January 10, 2013, therefore, a joint conference was held to hear argument on those issues. After the conference, on April 2, 2013, the ALJs sent a letter to DWC asking for guidance on those issues. The cases themselves were abated indefinitely in a joint order issued May 10, 2013. The Division's General Counsel replied to the ALJs' letter on September 30, 2013. The abatement in this case is lifted by this Decision and Order.

B. Motion to Dismiss and Jurisdiction

Carrier argues, in its Motion to Dismiss and supporting brief, that the critical disputed issue in this case is whether the services provided by Provider were related to the compensable injury, which was a lumbar strain/sprain. Carrier contends that it properly raised the relatedness issue, which is solely within the jurisdiction of the Division of Hearings, not the MRD. In its supporting brief, Carrier characterized the issue of whether treatment is causally connected to compensable

injury as an issue of compensability, which is addressed in chapter 410 of the Labor Code.[5]

Provider responded that the real issue, which Carrier failed to raise in its EOBs, was whether the services were reasonable and necessary for the treatment of the compensable injury. Provider also argued that if relatedness is a compensability issue, Carrier waived it by failing to provide a PLN-11 raising that issue in response to Providers' billing. Either way, Provider claims, because Carrier failed to raise the issue in accordance with the DWC rules and procedures, the issue was waived and MRD had authority to decide whether payment should be ordered.

DWC, in its September 3, 2013, letter to the ALJs, first observed that this dispute and the other disputes were filed prior to June 1, 2012, so former versions of the DWC rules applied. Under those rules, DWC stated,

> Extent-of-injury and related disputes are decided through the Tex. Lab. Code Chapter 410 and 28 Tex. Admin. Code Chapter 140 through 144 dispute resolution processes.
>
> To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Tex. Admin. Code § 133.204 [*sic*][6](e), (e)(1), (2)(C), and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury. 31 *Tex. Reg*. 3544, 3558 (April 28, 2006). Those provisions, in pertinent parts, specified:
>
> Former § 133.240(e), (e)(1), (2)(C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division …. The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the

[5] Carrier's Motion to Dismiss and Brief in Support of Motion to Dismiss, page 7. Specifically, Carrier quoted the Texas Workers' Compensation Commission's (DWC's predecessor's) 1998 responses to comments made regarding rules proposed at that time. *See* 23 *Tex. Reg*. 9563 (September 18, 1998).

[6] Although the letter says "133.204" at that point, it is clear from context that the intended cite was "133.240."

> injured employee when payment is denied because the health care was: … (C) unrelated to the compensable injury, in accordance with §124.2 of this title …. (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and §§ 124.2 and 124.3 of this title … if the insurance carrier reduces or denies payment for health care based solely on the insurance carrier's belief that: … (3) the condition for which the health care was provided was not related to the compensable injury.

Rule 133.240(e)(2)(C) makes it clear that, if a carrier determines that the health care provided was unrelated to the compensable injury, the carrier shall send notice in accordance with 28 TAC § 124.2. The relevant carrier reporting and notification requirements are set out in 28 TAC § 124.2 (d) and (f):

> (d) The carrier shall notify the Commission and the claimant of a denial of a claim (Denial) based on non-compensability or lack of coverage in accordance with this section and as otherwise provided by this title . . . .
>
> (f) Notification to the claimant as required by subsections (d) and (e) of this section requires the carrier to use plain language notices with language and content prescribed by the Commission. These notices shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim. A generic statement that simply states the carrier's position with phrases such as "employee returned to work," "adjusted for light duty," "liability is in question," "compensability in dispute," "under investigation," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

The only plain language notices provided by Carrier were sent before the treatments in question and related specifically to the extent of the injury. In both of those plain language notices, Carrier acknowledged that the compensable injury was a lumbar strain/sprain, which was the injury later set out by Provider in the diagnosis codes on the bills for treatment. Carrier did not send a plain language notice to Provider setting out its position that the treatments provided were unrelated to the compensable injury.

Carrier argues that Provider was aware that it was contesting the relatedness of the treatment to the compensable injury and that, therefore, it did not waive that issue. Regardless of whether the Provider was aware of the issue, however, Carrier was required to follow the DWC notification rules and did not do so. Carrier also contends that the argument that a waiver has occurred is a fact-intensive affirmative defense that must be adjudicated under Chapter 410. Carrier's argument, however, presumes an issue has properly been raised to invoke the provisions of Chapter 410. To dismiss the case or remand it the DWC Division of Hearings, if that is possible, would assume that the Division of Hearings has jurisdiction. This case is before SOAH; the issue of whether SOAH has jurisdiction and whether the MRD properly ruled on the dispute should be decided here.

The ALJ concludes that, even if the issue of relatedness generally is one for the Division of Hearings under Chapter 410, Carrier failed to raise the issue in accordance with DWC rules. Therefore, it waived that issue, and MRD properly had jurisdiction over the issue of whether Provider should be paid the amount in dispute, pursuant to Texas Labor Code 413.031. Carrier's Motion to Dismiss is therefore denied.

Carrier also specifically moved for dismissal of the claims for two dates of service—February 4 and 5, 2010--as untimely filed. Carrier observed that the request for medical fee dispute resolution was filed February 9, 2011, in apparent violation of 28 TAC §133.307(c), which requires filing within one year. Provider responded that 28 TAC §133.307(c)(1)(B) states that a party has 60 days from the date of a final decision on extent of injury to file for dispute resolution. Because the extent of injury issue was finally resolved on August 12, 2011, Provider argues, the request was not untimely.

The ALJ concludes that Provider's interpretation is correct. The motion to dismiss those specific claims is also denied.

II. REIMBURSEMENT

Considering that Carrier did not properly raise the issue, it is unclear whether the ALJ needs to address the issue of whether the services were, in fact, related to the compensable lumbar strain/sprain. Because it was discussed at the MRD and evidence was presented at the hearing, however, the ALJ will do so. Carrier's witness, Dr. Ira Posner, mostly testified about the utilization review process and the significance of preauthorization. He observed that the chronic pain management program, although preauthorized, was not specifically preauthorized for the compensable lumbar strain/sprain, so that issue was not resolved by preauthorization. Dr. Posner also observed that the Official Disability Guidelines (ODG) do not authorize a chronic pain management program for a compensable lumbar strain/sprain.

Dr. Tom Mayer, Provider's witness, did not agree with Dr. Posner's characterization of the ODG. He also discussed, in some detail, how, as in this case, a lumbar strain/sprain could fail to resolve completely and ultimately require a chronic pain management program. He observed that Claimant had been able to return to work after completion of the program.

Carrier did not address, and Provider did not discuss, the actual amounts set out for reimbursement in the MRD decision.

The preponderance of the evidence presented at the hearing showed that the services provided were related to the compensable injury. There was no evidence to show that the amounts authorized by the MRD decision were incorrect. Therefore, the ALJ finds those amounts to be reasonable and concludes that Carrier should reimburse Provider $21,895.07 for those services, plus applicable interest.

III. FINDINGS OF FACT

1. XL Specialty Insurance Co. (Carrier) challenges the Medical Fee Dispute Findings and

Decision of the Texas Department of Insurance, Division of Worker's Compensation (DWC), Medical Review Division (MRD), that ordered reimbursement of an additional $21,895.07 to PRIDE (Provider) for medical services provided to an injured worker (Claimant).

2. Claimant sustained a ___ at work on ___.

3. After Claimant filed his claim, Carrier filed Plain Language Notice forms (PLN-11s) regarding the extent of the compensable injury.

4. The first PLN-11, filed June 16, 2009, set out Carrier's contention that Claimant's compensable injury was limited to a low back sprain/strain and no other body parts.

5. The second PLN-11, filed November 10, 2009, reiterated that the compensable injury was limited to a lower back strain/sprain and specifically disputed Claimant's entitlement to treatment for peroneal neuropathy and lumbar degenerative disease.

6. Claimant received treatment in the form of epidural steroid injections and physical therapy. Although he was determined to be at maximum medical improvement by the designated doctor, he continued to complain of pain and restricted range of motion.

7. In February of 2010, Provider received preauthorization for chronic pain management program sessions, which Provider performed, along with other related services, between February 4 and April 21, 2010.

8. Although the treatments were preauthorized as medically necessary, that preauthorization did not guarantee reimbursement.

9. Provider billed the services to Carrier. The only diagnosis code contained on the bills was "847.2 Lumbar Sprain and Strain."

10. Carrier denied payment under various codes, including, on most of the bills, either "W12- Extent of injury. Not finally adjudicated" or "51- These are non-covered services because this is a pre-existing condition."

11. The EOBs did not specifically state that Carrier disputed that the treatments were related to the compensable injury.

12. Carrier did not file a PLN-11 stating that the Carrier disputed that the treatments were related to the compensable injury.

13. A Benefit Review Conference (BRC) was held July 26, 2010; however, the parties were unable to reach an agreement. Therefore, a contested case hearing was held before a DWC Hearing Officer on September 23, 2010, pursuant to Texas Labor Code chapter 410.

14. In a Decision and Order issued September 23, 2010, the Hearing Officer determined that the ____, compensable injury did not extend to and include L2 and L5 disc protrusion and that Claimant had reached maximum medical improvement on October 6, 2009, with an impairment rating of 0%. That Decision and Order was affirmed by the Appeals Panel on December 21, 2010.

15. The contested case hearing did not address the issue of whether Provider's February 4 through April 21, 2010, treatments were related to the compensable injury.

16. On February 18, 2011, Provider filed its Medical Fee Dispute Resolution Request with MRD, requesting reimbursement of an additional $22,622.66. Carrier's response asked MRD to review the request under Texas Labor Code §§ 413.011 and 413.031(c) and related DWC rules and stated Carrier's belief that the treatments at issue were not related to lumbar strain/sprain.

17. Carrier did not request dismissal of the Medical Fee Dispute Resolution request under 28 Texas Administrative Code (TAC) § 133.307(e)(3)(H).

18. Before MRD considered the request, a second BRC was held July 5, 2011, to determine whether the lumbar strain/sprain was compensable. Following the BRC, on July 6, 2011, the parties reached a signed agreement "that the compensable injury of ___, extends to and includes a low back strain/sprain." No other issues were addressed in that agreement. The agreement was signed by DWC on August 12, 2011.

19. MRD issued its Findings and Decision on April 23, 2012. MRD concluded there were no unresolved issues of extent of injury pertinent to the services in dispute. It denied reimbursement for CPT Codes 64483 and 77003 because they were related to the disc protrusions. It found that Provider sufficiently supported that the remaining services were for the compensable injury, and ordered Carrier to reimburse Provider $21,895.07.

20. Carrier filed a timely request for a hearing before the State Office of Administrative Hearings (SOAH).

21. Provider did not file a request for a hearing.

22. Before the SOAH hearing, Carrier filed its Motion to Dismiss the proceeding. Carrier argued that the issue of whether the treatment was actually related to the compensable injury should have been resolved by the DWC Division of Hearings, pursuant to Texas Labor Code chapter 410, before any request for Medical Dispute Resolution was filed, and that MRD

therefore had no jurisdiction to issue its Findings and Decision. Carrier asked SOAH to dismiss the case without prejudice so that the relatedness issue could be referred to and resolved by the DWC Division of Hearings under Texas Labor Code chapter 410.

23. The SOAH hearing was convened August 8, 2012, with both Carrier and Provider participating. The Motion to Dismiss was carried with the case. After the admission of documents and testimony, the hearing was adjourned.

24. The jurisdictional issues raised in Carrier's Motion to Dismiss in this case were also raised in other MRD cases before SOAH: Docket Nos. 454-12-5115.M4, 454-12-5870.M4, 454-12-6617.M4, 454-12-4228.M4, and 454-12-7138.M4. On January 10, 2013, therefore, a joint conference was held to hear argument on those issues.

25. After the joint conference, on April 2, 2013, the ALJs sent a letter to DWC asking for guidance on those issues.

26. The cases themselves were abated indefinitely in a joint order issued May 10, 2013.

27. The Division's General Counsel replied to the ALJs' letter on September 30, 2013.

28. Provider's request for medical dispute resolution was filed after the date of the final decision on extent of injury.

29. The reimbursement amounts set out the MRD Findings and Decision were reasonable.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.031(k) and Texas Government Code ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051 and 2001.052.

3. Under 28 TAC § 148.14(a), Carrier had the burden of proof in this proceeding.

4. Carrier did not timely raise the relatedness issue in accordance with former 28 TAC §§ 133.240(e)(2)(C) and 124.2.

5. Carrier waived its contention that the treatments provided were not related to the compensable service.

6. MRD properly had jurisdiction over the issue of whether Provider should be paid the amount in dispute, pursuant to Texas Labor Code § 413.031.

7. Carrier's Motion to Dismiss should be denied.

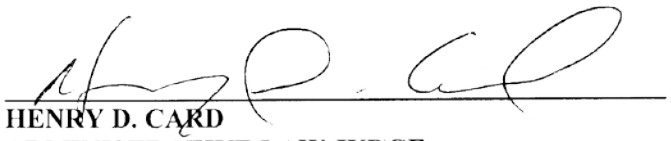
8. Carrier's specific Motion to Dismiss the claims for February 4 and 5, 2010, as untimely filed should be denied.

9. Carrier should reimburse Provider $21,895.07, plus applicable interest, for the services at issue.

ORDER

It is, therefore, ordered that XL Specialty Insurance Co.'s Motions to Dismiss are denied. XL Specialty Insurance Co. shall reimburse PRIDE the additional amount of $21,895.07, plus interest as appropriate, for the services at issue in this case.

SIGNED March 6, 2014.



HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS