BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TRAVELERS INDEMNITY CO. OF CONNECTICUT,
PETITIONER
V.
NORTH TEXAS PAIN RECOVERY CENTER,
RESPONDENT

DECISION AND ORDER

Petitioner Travelers Indemnity Company of Connecticut (Carrier) challenges the decision of the Texas Department of Insurance, Division of Workers' Compensation (Division) to order reimbursement of $16,750.00 to Respondent North Texas Pain Recovery Center (Provider).

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Provider challenged the jurisdiction of the State Office of Administrative Hearings (SOAH) to hear this matter by filing a plea to the jurisdiction. The plea to the jurisdiction was denied. Provider's arguments related to jurisdiction are discussed in the analysis section below.

On October 29, 2021, the Division received Provider's request for a Medical Fee Dispute Resolution (MFDR). On December 1, 2021, the Division issued its MFDR decision, finding that Provider was entitled to reimbursement in the amount of $16,750.00 plus interest. Carrier requested a hearing at SOAH to contest the Division's determination. On June 30, 2022, the Division issued a Request to Docket letter that, when combined with SOAH's order setting the hearing, dated August 1, 2022, served as a notice of hearing.

On October 20, 2022, SOAH ALJ Rebecca S. Smith convened a hearing on the merits via Zoom videoconference. Carrier appeared through attorney William Weldon. Provider appeared through its non-attorney representative, Brian Shepler. The record closed with the filing of exhibits that same day.

II. APPLICABLE LAW

This case involves a medical fee dispute for reimbursement under a workers' compensation policy provided by Carrier. If a health care provider is denied or paid a reduced amount for the medical service rendered to an injured employee, the

provider is entitled to review—the MFDR—by the Division.[1] If a dispute remains after that review, a party may request a contested case hearing at SOAH.[2] As the party requesting a hearing at SOAH to challenge an adverse medical fee dispute decision, Carrier has the burden of proof to show by a preponderance of the evidence that Provider is not entitled to reimbursement.[3] The hearing before SOAH is a de novo review of the issues involved.[4]

Not all workers' compensation reimbursement issues are resolved in an MFDR. Of relevance here, under Texas Insurance Code Section 1305.451, a carrier that establishes or contracts with a network is required to provide an employer a description of how to access care under the network.[5] The employer, in turn, is required to provide that information to employees.[6] Disputes "regarding whether an employer properly provided an employee with the information required by this section may be resolved using the process for adjudication of disputes under Chapter 410, Labor Code, as used by the [Division]."[7] Under Texas Labor Code chapter 410, which generally addresses adjudication of a carrier's liability for coverage for an injury or death, contested case hearings are handled by Division ALJs, not by an MFDR.[8]

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[1] Tex. Labor Code § 413.031(a).

[2] Tex. Labor Code § 413.0312(e).

[3] 28 Tex. Admin. Code § 148.14(b), (e).

[4] *See Vista Med. Ctr. Hosp. v. Texas Mut. Ins. Co.,* 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

[5] Tex. Ins. Code § 1305.451(a).

[6] Tex. Ins. Code § 1305.451(a).

[7] Tex. Ins. Code § 1305.451(e).

[8] Tex. Labor Code §§ 410.002,.151-.152.

The Division's rules addressing medical fee disputes set out several procedural requirements for requesting and responding to a MFDR. Among those requirements are that the party responding to a request may only address denial reasons that were presented to the requestor before the date the request for MFDR was filed.[9] Any new reasons for denial "shall not be considered in the review."[10]

The Division's rules also provide substantive requirements relating to workers' compensation. Carrier emphasizes one of those rules, which states that the treating doctor "is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury."[11] The treating doctor shall "except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to . . . other health care providers."[12]

III. EVIDENCE

Neither party presented testimony. Carrier introduced five exhibits, and Provider introduced four exhibits.

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[9] 28 Tex. Admin. Code § 133.307(d)(2)(F).

[10] 28 Tex. Admin. Code § 133.307(d)(2)(F).

[11] 28 Tex. Admin. Code § 180.22(c).

[12] 28 Tex. Admin. Code § 180.22(c)(1).

From November 18, 2020, through January 28, 2021, Provider provided pain management treatment to an injured worker covered by the workers' compensation system. Provider submitted claims for that treatment to Carrier.[13]

Carrier denied reimbursement and sent to Provider an Explanation of Benefits (EOB) form for each claim, listing several standard codes that set out the reasons for the denial. In this case, the primary issue involves code 5631, which states, "[t]he provider is not authorized to bill for this procedure/service."[14] This code is on all the EOBs but the last one.[15] Other codes Carrier provided in the EOB forms were:

15:	payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider;
45:	charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement;
P12:	workers' compensation jurisdictional fee schedule adjustment;
309:	the charge for this procedure exceeds the fee schedule allowance;
877:	reimbursement is based on the contracted amount; and
NRWK:	priced using Coventry-owned contract.

[13] Carrier Ex. 4. These claim forms are dated December 10, 2020; January 4, 12, 18, and 27, 2021; and February 1, 2021.

[14] Carrier Ex. 5 at 22, 26, 30, 34.

[15] Carrier Ex. 5 at 38.

In spring 2021, Provider requested a contested case hearing to challenge whether the injured worker's employer had provided him with the information about Carrier's network required by Texas Insurance Code section 1305.451. Without that information, Carrier could not use Petitioner's out-of-network status to deny reimbursement. This contested case, which was heard by a Division ALJ, only addressed the required network information. In a Decision and Order issued on September 28, 2021, the Division ALJ found that the employer and Carrier had not provided the required information. Accordingly, the Division ALJ found that Carrier could not deny reimbursement based on the Provider's out-of-network status.

Around a month later, Provider filed a request for an MFDR with the Division, challenging Carrier's other reasons for denying reimbursement.[16] In the MFDR response, Carrier argued that reimbursement should be denied because the claim forms submitted to Carrier indicate that the referring provider was Peter Grays, MD.[17] According to Carrier, Dr. Grays was not the injured employee's treating doctor. Instead, as set out on the Report of Medical Evaluation form submitted to the Division on behalf of the claimant, Candice Addison, MD, was the treating doctor.[18] Carrier argued that under the Division's rules, only the treating doctor could make a referral.[19]

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[16] Carrier Ex. 1. The Division received the request on October 29, 2021.

[17] Carrier Ex. 4.

[18] Carrier Ex. 3.

[19] *See* 28 Tex. Admin. Code § 180.22(c)(1).

The Medical Fee Dispute Resolution Officer found that Provider was entitled to $16,750.00 plus interest in reimbursement. In making this finding, the officer reviewed the separate billing requests and the codes Carrier provided in the EOBs in response to each of the billing requests. Of particular significance is the officer's finding that the use of code 5631 did not inform Provider that the Carrier's concern was the status of the doctor who had referred the injured worker for treatment:

> The insurance carrier in its position statement argued "As stated on the Carrier's Explanation of Benefits, denial reason 5631, this provider is not authorized to bill for this procedure/service, as the Provider was not approved or referred by the Treating Doctor."
>
> The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before . . . the request for [MFDR] was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review. The submitted documentation does not support that a denial based on not approved or referred by the treating doctor was provided to the requestor before this request for MFDR was filed. Therefore, the [Division] will not consider this argument in the current dispute review.

IV. ANALYSIS

Carrier raises two main issues in its challenge to the MFDR decision. The first issue is whether, contrary to the MFDR finding, Carrier raised the referral issue with Provider before the MFDR was filed. If the issue was not timely raised, it

may not be considered here. Assuming the referral dispute was timely raised, then the second issue is whether Carrier established that as a valid reason for denial.

Carrier's first issue depends on the meaning of code 5631 in the EOBs. If code 5631 is, as Carrier argues, broad enough to inform Provider that someone other than the treating physician referred the injured worker to Provider for treatment, then the MFDR should have addressed denial on this basis. If Carrier's use of the code did not inform Provider that it was denying reimbursement because of this improper referral, then the Division's rules prevent that reason from being considered in this matter.

In response to Carrier, Provider argues that SOAH lacks jurisdiction and that res judicata bars Carrier's argument. It alternatively argues that Code 5631—"[t]he provider is not authorized to bill for this procedure/service"—only means that a provider is out of network.

A. Jurisdiction

Beginning with Provider's jurisdiction arguments, the ALJ notes that this matter is a review of the MFDR, which Provider itself filed with the Division. SOAH generally has jurisdiction to conduct de novo reviews of MFDR decisions.[20] The ALJ finds that SOAH has jurisdiction over this matter.

[20] Tex. Labor Code § 413.0312(e).

B. Res Judicata

Res judicata, or claim preclusion, "prevents the relitigation of a claim or cause of action that has been finally adjudicated, as well as related matters that, with the use of diligence, should have been litigated in the prior suit."[21] The Division Decision and Order addressed whether the injured employee had been given information about the Carrier's network, the consequence of which was the Carrier could not deny reimbursement based on Provider's out-of-network status.

But Carrier is not currently arguing that it may deny reimbursement on out-of-network status. Instead, it argues that reimbursement should be denied based on an improper referral. Provider does not argue that referral issues should have been, or could have been, addressed in the previous Division proceeding that resulted in the Decision and Order. Res judicata does not apply here.

C. Code 5631

Carrier argues that it explained to Provider that it was denying reimbursement based on the referring doctor when it used code 5631—that the provider was not authorized—in the EOB. Carrier argues that all the standardized codes, such as 5631, are necessarily broad so there could be many reasons why the provider could have been unauthorized. Thus, it argues, it provided the information to Provider before the MFDR, so it is not barred from presenting it in

[21] *Barr v. Resolution Trust Corp. ex rel. Sunbelt Fed. Sav.*, 837 S.W.2d 627, 628 (Tex. 1992).

this proceeding. For its part, Provider presented its understanding that code 5631 only means that a provider was out of network.

The issue here is whether Carrier's reason for the denial—that the referral was from a doctor who was not listed as the treating doctor—was presented to the Provider before it filed the MFDR.[22] Even if Carrier is correct that code 5631 is so broad that a provider could be unauthorized for many different reasons, then that code is so broad that does not satisfy the requirement of presenting an explanation to a provider before raising it in the MFDR. This is particularly the case because that code also appears to be the one used to indicate that Provider was out of network. The ALJ agrees with the MFDR finding that Carrier did not present Provider with the referral explanation before the MFDR filing, so that explanation cannot be addressed in the MFDR. Accordingly, the question of whether the referral was proper does not need to be addressed here, either.[23]

For this reason, the ALJ concludes that Carrier has not met its burden and the MFDR decision ordering reimbursement of $16,750.00 plus interest should be upheld.

[22] 28 Tex. Admin. Code § 133.307(d)(2)(F).

[23] Similarly, the effect of not including code 5631 on the February 1, 2021 EOB will not be addressed, either.

V. FINDINGS OF FACT

1. From November 18, 2020, through January 28, 2021, North Texas Pain Recovery Center (Provider) provided pain management for an injured worker covered by the workers' compensation insurance system.

2. Provider submitted claims for the injured worker's treatment to Travelers Indemnity Company of Connecticut (Carrier).

3. Carrier denied reimbursement and sent to Provider an Explanation of Benefits (EOB) form for each claim, listing several standard codes that set out the reasons for its denial.

4. Throughout the EOB forms, Carrier used the following codes to explain the denial:

    a. code 5631: The provider is not authorized to bill for this procedure/service;

    b. code 15: Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider;

    c. code 45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement;

    d. code P12: Workers' compensation jurisdictional fee schedule adjustment;

    e. code 309: The charge for this procedure exceeds the fee schedule allowance;

    f. code 877: Reimbursement is based on the contracted amount; and

    g. code NRWK: priced using Coventry-owned contract.

5. Carrier's use of code 5631—or any other code—did not give Provider the information that Carrier was denying reimbursement based on the identity of the referring doctor.

6. In spring 2021, Provider requested a contested case with the Texas Department of Insurance, Division of Workers' Compensation (Division) hearing to challenge whether the injured worker's employer had provided him with information about Carrier's network, as required by Texas Insurance Code section 1305.451.

7. The only issue that was raised in that challenge was whether the network information had been provided.

8. In a Decision and Order issued on September 28, 2021, the Division Administrative Law Judge (ALJ) found that the employer and Carrier had not provided the required information on its network. Accordingly, the Division ALJ found that Carrier could not deny reimbursement based on the Provider's out-of-network status

9. On October 29, 2021, the Division received Provider's request for a Medical Fee Dispute Resolution (MFDR).

10. In the MFDR response, Carrier argued that reimbursement should be denied because the claim forms submitted to Carrier indicate that the referring provider was Peter Grays, MD. According to Carrier, Dr. Grays was not the injured employee's treating doctor. Instead, as set out on the Report of Medical Evaluation form submitted to the Division on behalf of the claimant, Candice Addison, MD, was the treating doctor.

11. On December 1, 2021, the Division issued its MFDR decision, finding that Provider was entitled to reimbursement in the amount of $16,750.00 plus interest.

12. As part of that MFDR decision, the officer determined that before the MFDR was filed, Carrier had not given Provider the explanation that the referral was not made by the treating doctor.

13. Carrier timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest the Division's determination.

14. On June 30, 2022, the Division issued a notice to the parties with a statement of the nature of the hearings; 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 either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

15. On August 1, 2022, the SOAH ALJ issued an order with the statement of the time and place of the hearing and instructions for participating in the hearing.

16. On October 20, 2022, SOAH ALJ Rebecca S. Smith convened a hearing on the merits via Zoom videoconference. Carrier appeared through attorney William Weldon. Provider appeared through its non-attorney representative, Brian Shepler. The record closed with the filing of exhibits that same day.

17. The only basis for denial Carrier presented at the SOAH hearing was that the referring doctor was not the treating doctor.

VI. CONCLUSIONS OF LAW

1. Adequate and timely notice of the hearing was provided to the parties. Tex. Gov't Code §§ 2001.051-.052.

2. If a health care provider is denied or paid a reduced amount for the medical service rendered to an injured employee, the provider is entitled to review—the MFDR—by the Division. Tex. Labor Code § 413.031(a).

3. If a dispute remains after the MFDR review, a party may request a contested case hearing at SOAH. Tex. Labor Code § 413.0312(e).

4. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Labor Code §§ 413.031, .0312(e); Tex. Gov't Code ch. 2003.

5. Unlike an MFDR, disputes regarding whether an employer properly provided an employee with required information on a carrier's network can be resolved by a Division ALJ. Tex. Ins. Code § 1305.451(e).

6. Res judicata, or claim preclusion, "prevents the relitigation of a claim or cause of action that has been finally adjudicated, as well as related matters that, with the use of diligence, should have been litigated in the prior suit." *Barr v. Resolution Trust Corp. ex rel. Sunbelt Fed. Sav.*, 837 S.W.2d 627, 628 (Tex. 1992).

7. The September 28, 2021 Division Decision and Order, limited to addressing network information, does not prevent SOAH from addressing the issues raised in this hearing because those issues belong in an MFDR.

8. Carrier, as the party challenging the MFDR decision, has the burden of proof. 28 Tex. Admin. Code § 148.14(b).

9. The hearing before SOAH is a de novo review of the issues involved. *See Vista Med. Ctr. Hosp. v. Texas Mut. Ins. Co.,* 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

10. A party responding to a MFDR request may only address denial reasons that were presented to the requestor before the date the request was filed. Any new reasons for denial "shall not be considered in the review." 28 Tex. Admin. Code § 133.307(d)(2)(F).

11. Because Carrier's denial based on the role of the referring doctor was not presented to Provider before the MFDR, this basis cannot be considered.

VII. ORDER

It is **ORDERED** that Carrier is required to reimburse Provider $16,750.00 plus interest.

VIII. NONPREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the nonprevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to

identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, Carrier is the nonprevailing party. The costs associated with this decision are set forth in Attachment A to this Decision and Order and are incorporated herein for all purposes.

Signed December 15, 2022.

ALJ Signature(s):

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Rebecca Smith
Presiding Administrative Law Judge