# Dispute Resolution when Medical Bills are Denied for Compensability, Extent of Injury, Relatedness, or Liability Part I

Health Care Provider Outreach

# Disclaimer

This presentation is for educational purposes only and provides general information. It is not a substitute for a full review of statutes and rules.

System participants are responsible for knowing and complying with the applicable sections of the Texas Insurance Code (Insurance Code), Texas Labor Code (Labor Code) and Texas Administrative Code (TAC).

Any opinions expressed by the speakers are personal and do not constitute or reflect any statement of policy by the Texas Department of Insurance, Division of Workers' Compensation (DWC).

# Overview

- Definition of compensability.
- Notice of injury and disputes.
- Avoiding denials for compensability, extent of injury, relatedness or liability (CERL).
- Identifying a medical bill denial for CERL.
- Next steps and dispute paths.
- DWC Resources

# What is a compensable injury?

An injury that arises out of and in the course and scope of employment for which compensation is payable under Title 5 of the Texas Labor Code (Labor Code).

# What does course and scope of employment mean?

An activity …

- that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer…
- on the premises of the employer or at other locations.

# Why is it important?

- Insurance carrier is only liable to pay benefits for a compensable injury (claim).
- Insurance carrier may dispute the compensability of the injury, the extent of the compensable injury, relatedness of the services, or liability for the injury.
- CERL disputes are called benefit disputes.

# Compensability or Liability Disputes

**Sometimes, the workers' compensation insurance carrier may not be liable.**

Examples are when the employee:

- Intentionally caused their own injuries.
- Was injured while playing around or while intoxicated.
- Was injured outside of work or while voluntarily participating in an off-duty sports or social event.

See more exceptions in Labor Code Sec. 406.032. *Exceptions*

# Compensability or Liability Disputes

Typical compensability disputes are about course and scope:

- whether the injury, illness, condition or death was caused by work activities; or
- whether the injury, illness, condition or death was an exception to liability.

# Why is it important?

A health care provider may not know about disputed CERL issues until:

- **After** medical services are provided and a medical bill is denied for a CERL reason, or
- **Before** medical services are provided and a written preauthorization approval includes a notice of any unresolved CERL dispute.

Understanding these processes may help you avoid CERL denials and resolve issues, if they occur.

# First Report of Injury - Employee

Employee notifies employer.

- not later than the 30th day after the date on which the injury occurs,
- 28 TAC Sec. 122.1. *Notice to Employer of Injury or Occupational Disease*.

# First Report of Injury - Employer

Employer files a DWC Form-001. *Employer's First Report of Injury or Illness* to the insurance carrier.

- Within 8 days after the employee's absence from work for more than one day or receipt of an occupational disease.
- 28 TAC Sec. 120.2. *Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities.*

# Notice of Injury – Insurance Carrier

Insurance carrier's written notice of injury (NOI) is the earliest receipt of:

- Employer's First Report of Injury;
- Notification from DWC; or
- If no Employer's First Report of Injury has been filed, any other communication regardless of source that fairly informs the insurance carrier of the name of the injured employee, the employer, the approximate date of injury, and information that it is was a work-related injury (ex. medical bill). NOTE: Carrier must follow 124.1(f) by contacting the employer within 7 days of receipt.

# Investigation of Injury

Upon receipt of a written NOI, the insurance carrier begins investigation of:

- compensability of the injury,
- the liability for the injury, and
- the accrual of benefits.

# Compensability or Liability Dispute

If the insurance carrier disputes compensability or liability the insurance carrier issues a denial notice.

Notice of Denial of Compensability/Liability and Refusal to Pay Benefits (PLN01) is submitted to:

- DWC
- claimant; and
- contracted network health care provider for a network claim.

NOTE: Notice does not go to health care providers treating non network claims.

# That means…

PLN01 filed between 15th and 60th day after receipt of written NOI, the insurance carrier is liable and must pay all medical services provided **prior** to filing the PLN01.

- Find the date the PLN01 was filed (get a copy).
- Present this information during reconsideration or during a hearings proceeding (BRC or CCH).

28 TAC 124.3 (a). *Investigation of an Injury and Notice of Denial or Dispute*

# Notice to Network Provider

Insurance Code Sec. 1305.153. *Provider Reimbursement*

Insurance carrier shall notify in writing a network provider if the insurance carrier contests the compensability of the injury for which the provider provides health care services.

# Notice to Network Provider

Prior to providing written notification to network health care provider:

- Insurance carrier may not deny payment for medically necessary health care services based on compensability; and
- Insurance carrier is liable for up to a maximum of $7,000 for medically necessary health care services provided prior to notification.

# Notice of Disputed Issue for Extent of Injury or Relatedness

When an insurance carrier receives information (ex: medical bill and supporting medical records) it may dispute:

- whether a new injury, illness, or medical condition was caused by or extends to the original work injury (extent); or
- whether a medical treatment is related to the compensable injury (relatedness).

# Notice of Disputed Issue for Extent of Injury or Relatedness

Notice of Disputed Issue(s) and Refusal to Pay Benefits (PLN11):

PLN11 should be filed not later than the earlier of:

- date the insurance carrier denied the medical bill; or
- due date for the insurance carrier to pay or deny the medical bill.

# That means…

PLN11 can be issued at any time during the life of the claim as the insurance carrier receives new information about conditions being treated and services being rendered.

# Designated Doctor Extent of Injury Exam

Designated doctor determines if conditions previously denied by the insurance carrier are part of the compensable injury.  If DD determines yes, they are:

- Insurance carrier must reprocess and pay all medical bills previously denied for reasons inconsistent with the findings of the designated doctor.
- Insurance carrier has 21 days from receipt of the designated doctor's report to reprocess.

28 TAC Sec. 127.10 (i). *General Procedures for Designated Doctor Examinations*

Key Questions

# Avoiding Medical Bill Denial for CERL

# Ask the Injured Employee

Is the treatment you are seeking due to a work-related injury?

- Ask all patients this question and get their response in writing.
- It may help to ask this question more than once and expressed differently.

  ex: Where did this injury occur? Were you working at the time of the injury?

# Ask the Injured Employee

- Do you have any outstanding disputes on CERL issues (PLN01 or PLN11)?*
- Has the insurance carrier told you that you are not entitled to workers' compensation benefits?

* Insurance carrier is required to send notice of any benefit disputes (PLN01 or PLN11) directly to the injured employee (claimant). Ask for a copy.

# Ask the Referring Health Care Provider

Are you aware of any disputes on CERL?  If yes, ask:

- What conditions have been disputed and ask for copy of the PLN01 or PLN11.
- Do they have medical bills denied for this reason?
  - If yes: have they pursued dispute resolution?
  - If yes: what was the outcome?
- If there is a dispute over CERL, will they help (i.e., causation information, participation)?

# Ask the Insurance Carrier's Adjuster

Are there any outstanding CERL disputes on the claim?
If yes:

- Ask for a copy of the outstanding PLN01 or PLN11 (to review the conditions/dx being disputed).
- Insurance carrier is not required to send the PLN01 or PLN11 to the health care provider, except in these cases:
  - network claims, and
  - during the preauthorization process.

# Explanation of Benefits

## Determine When a Medical Bill is Denied for CERL Reasons

# Communication between Health Care Providers and Insurance Carriers

28 TAC Sec. 133.3. *Communication between Health Care Providers and Insurance Carriers*.

- Communication relating to medical bill processing must be sufficient and specific enough to allow the responder to easily identify the information necessary to resolve the matter.
- Must be made by telephone, electronic transmission, and if not able to by that media,  mail or personal delivery.
- Maintain documentation of communications.

# Explanation of Benefits (Remittance) Codes

Insurance carriers must use claim adjustment reason codes (CARCs) on explanation of benefits.

- adjustment reason code that conforms to the standards described in 28 TAC Sec.133.500 and 133.501 of this title if total amount paid does not equal total amount charged.
- 28 TAC Sec. 133.240. *Medical Payments and Denials* for paper and electronic EOBs.

# Explanation of Benefits (Remittance) Codes

Insurance carriers must use claim adjustment reason codes (CARCs) on explanation of benefits.

- 28 TAC Sec. 133.500. *Electronic Formats for Electronic Medical Bill Processing,* ASC X12 835 data elements.
- Claim Adjustment Reason Codes can be found at X12.org, external code list 139.
- Insurance carriers may supplement with additional information.

# CERL Claim Adjustment Reason Codes

## Explanation of Benefits (EOB)

**219** - Based on extent of injury

**P2** - Not a work-related injury/illness and thus not the liability of the workers' compensation carrier

**P4** - Workers' compensation claim adjudicated as non-compensable

**P6** - Based on entitlement to benefits

**P8** - Claim is under investigation

Supplemental descriptions may include:
"Billed charges submitted not all related to compensable injury."

# EOB Denial - Compensability

| Date | Code | | Units | POS | Bill Charges | TOS | DXR | Reduction | Allowed Fees |
|---|---|---|---|---|---|---|---|---|---|
| 09/07/21 | 90837 | PSYCHOTHERAPY W/PATIENT 60 MINUTES | | | $350.00 | | | $350.00 | $0.00 |
| | P6 | | 1 | 11 | | | A | | |
| **Sub-Totals for Bill: 3342483** | | | | | **$350.00** | | | **$350.00** | **$0.00** |
| **Totals for Bill:3342483** | | | | | | | | | **$0.00** |

**Line Item Reason Codes and Descriptions**
P6 Based on entitlement to benefits

# Compensability Dispute Notice (PLN01)

**We,** the insurance company **reviewed your workers' compensation claim. Based on the facts we have about your claim, we are not going to pay income or medical benefits.**

**We denied your claim because:**

Based on our investigation, you did not suffer a compensable work related injury within the course and scope of employment of your employer and you failed to timely notify your employer within 30 days of the alleged injury. Based on our investigation, there are fact discrepancies in regards to the mechanism of injury and to whom and when the alleged injury occurred and was reported. In addition, you did not sustained damage or harm to the physical structure of your body while in furtherance of the affairs of your employer. You did not sustain an injury arising out of or within the course and scope of employment. The carrier contends that you are suffering from an ordinary disease/condition of life to which the general public is exposed outside of employment

**Contact me if you: (1) have questions, (2) need to give more facts about this claim, or (3) disagree with this decision.**

# EOB Denial – Extent of Injury and Relatedness

**Diagnosis code(s) submitted:** (A) S63.8X1A (R) wrist s/s (B) S33.5XXA L-spine s/s (C) S70.00XA hip contusion

| DOS | Service code | | | ICD | Units | Charges | Paid |
|---|---|---|---|---|---|---|---|
| 04/27/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/27/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/27/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/27/2021 | 97112 | GO | NEUROMUSCULAR REEDUCATIO<br>219 246 | A,B,C | 1 | $53.00 | $0.00 |
| 04/29/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/29/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/29/2021 | 97110 | GO | THERAPEUTIC EXERCISES<br>219 246 | A,B,C | 1 | $55.00 | $0.00 |
| 04/29/2021 | 97112 | GO | NEUROMUSCULAR REEDUCATIO<br>219 236 246 435 | A,B,C | 1 | $53.00 | $0.00 |
| 04/29/2021 | 98940 | | CHIROPRACT MANJ 1-2 REGI<br>219 16 246 762 225 | A,B,C | 1 | $55.00 | $0.00 |

**CAC-16** CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
**CAC-219** BASED ON EXTENT OF INJURY.
**CAC-236** THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERS COMPENSATION STATE REGULATIONS/FEE SCHEDULE REQUIREMENTS.
**225** THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
**246** THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE EXTENT OF INJURY. FINAL ADJUDICATION HAS NOT TAKEN PLACE.
**435** PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
**762** TREATMENT/SERVICE IN EXCESS ODG/DWC TREATMENT GUIDELINES IN ACCORDANCE WITH TAC RULE 134.502,503 & 134.600(P)(12)

# Extent of Injury Dispute Notice (PLN11)

**We, [redacted] Insurance Company, reviewed your workers' compensation claim. Based on the facts we have about your claim, we don't agree:**

- ☐ That your work-related injury stops you from getting or keeping a job that pays what you earned before your injury (existence, duration, or extent of disability).
- ☑ That some of your medical conditions were caused by your work-related injury (extent of injury).
- ☐ That you meet the rules for getting death benefits.

**We don't agree because:** [redacted] Insurance Company disputes that the compensable injury of [redacted] 2017 extends to include the current medical condition. Based on the Peer Review medical opinion of Dr. [redacted] dated [redacted] 2020, the compensable injury is not a producing cause of the employee's current condition.

[redacted] continues to dispute lumbar facet joint pain at L4-5 and L5-S1, left hip pain, chronic pain syndrome, severe degenerative changes and disc disease at L5-S1, joint somatic dysfunction, non-allopathic lesions of the pelvis and lumbar radiculopathy.

**Contact me if you: (1) have questions, (2) need to give more facts about this claim, or (3) disagree with this decision.**

# What is next after a denial for CERL?

**Do not** bill the injured employee (pursue a private claim), unless there is final adjudication from DWC for that condition and related services.

Labor Code Sec. 413.042. *Private Claims; Administrative Violation.*

# What is next after a denial for CERL?

- Insurance carrier's EOB is not final adjudication.
- Final adjudication is a final decision or order issued by DWC that is no longer subject to appeal by either party.
- Obtained through the DWC benefit dispute resolution process.

# What is next after a denial for CERL?

**Do not** file for Medical Fee Dispute Resolution (DWC Form-060) this is not a dispute over reimbursement (fees).

**Do:**

- Develop a position statement, with any necessary causation or relatedness information.
- Attempt to resolve the issue with the injured employee and insurance carrier by requesting reconsideration (document this effort).

28 TAC Sec. 133.250. *Reconsideration for Payment of Medical Bills*

# What is next after a denial for CERL?

**Do:**

- Follow the DWC benefit dispute resolution process as a subclaimant.
- Follow important rules for dispute resolution:

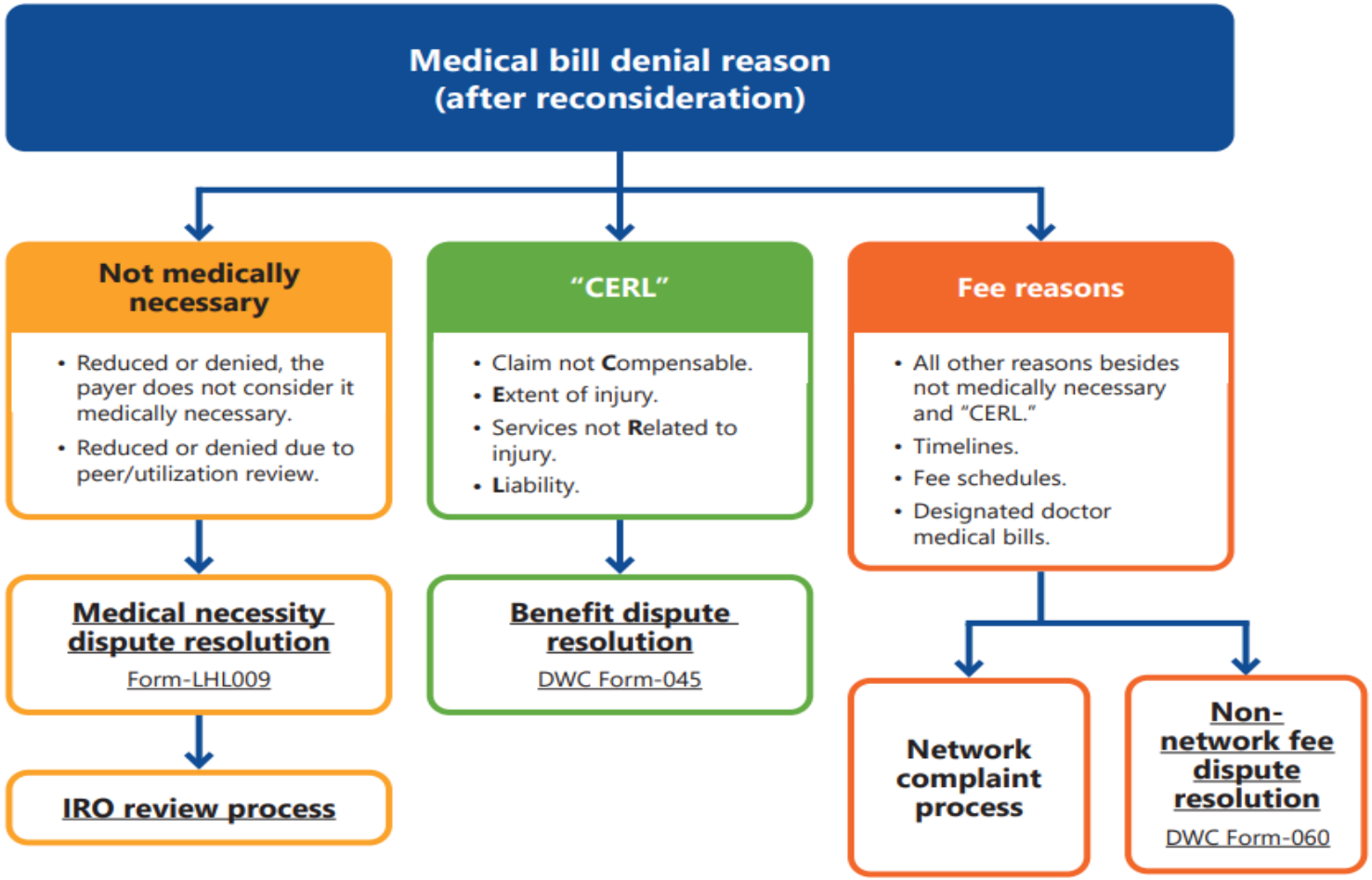
✓28 TAC Sec. 140.6. *Subclaimant Status: Establishment, Rights, and Procedures*.

✓28 TAC Sec. 141.1. *Requesting and Setting a Benefit Review Conference*.

✓DWC Form 045, Request to schedule, reschedule, or cancel a benefit review conference.

# DWC Resources

# Medical bill denial dispute paths

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# DWC Fast Facts for Health Care Provider Subclaimants

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Home > Workers' Compensation > Health care provider training and resources > Medical billing

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- Disciplinary orders
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## Medical billing

The rules in 28 Texas Administrative Code (TAC) Chapter 133 apply to both non-network and network medical bills with some network exceptions.

**General rules for medical billing and documentation**

**Requirements for paper and electronic medical bill processing**

**Medical bill and preauthorization denials**

- Disputes vs. complaints fast facts
- Steps for dispute resolution of a medical bill denial
- Medical necessity dispute resolution
  - Non-network preauthorization/concurrent review process flowchart
  - Non-network retrospective review process flowchart
  - Independent review organization (IRO) process
- Benefit dispute resolution (compensability, extent of injury/relatedness or liability
- Medical fee dispute resolution
- Federal military treatment facility disputes

# Review

- Definition of compensability.
- Notice of injury and disputes.
- Avoiding denials for compensability, extent of injury, relatedness or liability (CERL).
- Identifying a medical bill denial for CERL.
- Next steps and dispute paths.
- DWC Resources


# Let's flex your knowledge!

# Contact Us

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