SOAH DOCKET NO. 453-03-4391.M4
TWCC MDR NO. M4-03-2676-01

HOUSTON PREMIER DURABLE MEDICAL EQUIPMENT, Petitioner	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
STATE OFFICE OF RISK MANAGEMENT, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Houston Premier Durable Medical Equipment (Petitioner) appealed the findings and decision of the Texas Workers' Compensation Commission's designee, an independent review organization (IRO), which upheld the State Office of Risk Management's (SORM) denial of reimbursement for a pair of knee braces provided to a workers' compensation claimant (Claimant), pursuant to a prescription by Claimant's treating doctor. SORM denied reimbursement for lack of the required preauthorization and asserted Claimant had already received knee braces. The IRO decision denied reimbursement based on its finding that Petitioner used the wrong billing code on its claim for reimbursement. This decision and order finds reimbursement should be paid because the items did not require preauthorization, were not duplicative of other goods, and the billing code used was adequate.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

There were no contested issues of notice or jurisdiction. Therefore, those matters are set forth only in the Findings of Fact and Conclusions of Law without further discussion.

On January 6, 2004, the hearing in this matter convened at the State Office Of Administrative Hearings (SOAH), 300 W. 15th Street, 4th Floor, Austin, Texas, before SOAH Administrative Law Judge (ALJ) Ann Landeros. Petitioner was represented by its designated employee representative, Alex Cuevas. Staff attorney Keith Martin represented by SORM. Respondent Commission chose not to participate in the hearing. After receipt of evidence and argument, the record closed that date.

II. DISCUSSION

A. Background

Claimant sustained a compensable injury in ___. At the time of the injury, SORM was responsible for providing workers' compensation insurance coverage for Claimant. In January 2002, Claimant's treating doctor, Joe Garza, M.D., prescribed bilateral custom knee braces for Claimant.

SORM refused to preauthorized Claimant's request for custom-fitted knee braces. In the preauthorization denial, the SORM reviewer wrote:

> Based on the review of medical necessity, [the medical utilization reviewer] has non-authorized the request for bilateral custom knee braces. Patient can benefit from off the shelf braces just as well. There is no medical necessity for custom knee braces. (Pet. Exh. 1, p. 10).

After receiving the denial for custom knee braces, Dr. Garza prescribed off-the-shelf bilateral hinged knee braces on January 24, 2002, which Petitioner fitted Claimant with. Petitioner billed SORM for the braces under CPT code L1832, adding "NU" after the code. The descriptor for CPT code L1832 reads: "KO, adjustable knee joints, positional orthosis, rigid support, custom fitted." Each brace cost $499, but Petitioner billed them as a pair, in the total amount of $998.

On January 18, 2002, SORM approved reimbursement of $180 for a pair of knee braces for Claimant billed under CPT code L1810. The reimbursement form for this claim listed Ali Mohamed, M.D., as the referring physician. CPT code L1810 describes the item as: "KO, elastic with joints."

SORM originally denied reimbursement for the braces Petitioner provided using the denial code "Z1" (preauthorization required). Upon Petitioner's request for reconsideration, SORM added the denial codes "D" (duplicate charge) and "O" (no additional benefit recommended after reconsideration).

Petitioner appealed the denial to the Commission, which referred the appeal to an IRO. The IRO found Petitioner used the wrong billing code because it included the modifier "NU" after the CPT code, which was not recognized in the Commission's 1996 Medical Fee Guideline (MFG).

Petitioner timely appealed the IRO decision.

B. Arguments

Petitioner argued that each brace cost under $500 and so did not require preauthorization. It further argued SORM's representative had preauthorized purchase of the off-the-shelf braces when the request for custom braces was denied.

Carrier argued that the braces were not medically necessary, involved a duplicative charge, and were provided without necessary preauthorization. It also supported the IRO's decision that no reimbursement was due because Petitioner billed using an unrecognized CPT code modifier.

C. Legal Standards

Petitioner has the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC 155.41. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a). Health care includes all reasonable and necessary medical services including a medical appliance or supply. TEX. LAB. CODE ANN. §401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31). The IRO was authorized to hear the medical dispute pursuant to 28 TAC § 133.308.

For a carrier to be liable for reimbursement of durable medical equipment, the DME must be preauthorized unless the item costs less than $500. 28 TAC § 134.600. To reimbursed for services, a provider must submit a complete bill including the correct billing codes from the Commission fee guidelines on the Commission approved forms. See 28 TAC §§ 133.1(a)(3)(C), 134.1, and 134.800. A carrier has a duty to communicate with the provider, within seven days of receipt of a bill, to resolve inaccurate or incomplete billings. See 28 TAC 133.300. Within forty-five days of denying a bill, the carrier must provide the provider with an explanation of benefits listing the correct denial of benefits code. 28 TAC § 133.304. With the provider's permission, the insurance carrier can change a billing code and can request additional documentation which the provider must submit within fourteen days of the request. 28 TAC § 133.301.

D. Evidence

SORM presented the testimony of Petitioner's office manager, Mr. Cuevas. Mr. Cuevas stated that the knee braces provided Claimant were off-the-shelf. He billed them as "fitted" because the braces come in three sizes (small, medium, large) and the patient has to be fitted for the right size. They were not custom braces, which are fitted according to numerous specific measurements and cost at least $1000 a piece ($2000 and up for a pair). Petitioner did not seek preauthorization for the off-the-shelf braces because each knee brace cost under $500, so did not require preauthorization. Additionally, if preauthorization were required, Petitioner believed the statement in SORM's January 24, 2002, denial letter (Pet. Exh. 1, p. 10) that Claimant could benefit from off-the-shelf braces just as well constituted preauthorization.

Mr. Cuevas used the CPT code L1832 to claim reimbursement because that CPT code most accurately described the DME provided. He admitted the braces were not "custom fitted" as described in the CPT code, but chose it because the braces were "fitted" and otherwise fit the descriptor. The "NU" that followed the CPT was simply Petitioner's in-house code that signified the item was not available for purchase and is also a modifier used by Medicare.

E. Analysis

The evidence established that each brace was a separate item of DME and cost under the $500 threshold amount for preauthorization under 28 TAC § 134.600. Therefore, Petitioner proved that preauthorization was not necessary for either knee brace.

The IRO had no basis for going beyond SORM's denial codes and disallowing the bill based on the addition of the "NU" billing modifier. The purpose of the CPT codes is to identify the specific good or service. Both Petitioner and SORM knew from the inception of this dispute what goods were provided to Claimant. Because TWCC does not have an "NU" modifier, Petitioner's use of that modifier was not misleading-it was simply meaningless. There was no equitable basis to deny reimbursement based on inclusion of a meaningless, but not misleading, modifier.

SORM had a duty to inform Petitioner if it did not understand what item was being billed. It never did so. In both the original and reconsideration EOB, SORM described the items as "KO adjust joint position," which showed that SORM knew what the bill was for. In its EOBs, SORM claimed only lack of preauthorization and duplicate charges as grounds for the denial. In a reimbursement challenge, the denial codes used by the carrier in the EOB or other communication with the provider are the only grounds which may be reviewed. SORM did not assert incorrect

coding or lack of medical necessity as a basis for the denial in its EOBs and is not entitled to rely on that challenge now, absent some unusual circumstances not established in this case.

Provider is entitled to reimbursement despite the fact that SORM had already approved reimbursement for a different type of knee brace prescribed by a different referring physician and provided by a different provider. There was no evidence to show that the braces prescribed by Dr. Mohamed were duplicative of those prescribed by Dr. Garza. Judging by the CPT code descriptors, the two set of braces had significantly different features (only one pair was hinged, adjustable, and fitted). SORM had the duty to adequately explain the "D" denial codes so that Petitioner could have either confirmed or refuted it. The record did not establish that SORM ever gave any information to Petitioner about the "D" denial code, a failure which deprived Petitioner of its right to refute the applicability of that code.

III. FINDINGS OF FACT

1. Claimant sustained a compensable injury in ___.

2. At the time of the injury, the State Office of Risk Management (SORM) was responsible for providing workers' compensation insurance coverage for Claimant.

3. In January 2002, Claimant's treating doctor, Joe Garza, M.D., prescribed hinged, custom-fitted bilateral knee braces for Claimant.

4. SORM refused in writing to preauthorized Claimant's request for custom-fitted knee braces, but stated that Claimant could benefit from off-the-shelf braces.

5. After receiving the denial for custom knee braces, Dr. Garza prescribed off-the-shelf bilateral hinged knee braces on January 24, 2002, which Petitioner fitted Claimant with.

6. Petitioner billed SORM for the braces under CPT code L1832, adding "NU" after the code.

7. The Commission's medical fee guidelines do not use the modifier "NU," so inclusion of that modifier after the L1832 code was meaningless.

8. CPT code L1832 was the code most accurately describing the knee braces Petitioner provided.

9. The "NU" modifier after the CPT code did not confuse or mislead SORM.

10. SORM did not adequately explain the "D" denial code.

11. SORM did not deny reimbursement based on the inclusion of the "NU" code or lack or medical necessity.

12. Each brace cost $499, but Petitioner billed them as a pair, in the total amount of $998.

13. On January 18, 2002, SORM approved reimbursement of $180 for a pair of knee braces for Claimant billed under CPT code L1810. The reimbursement form for this claim listed Ali

Mohamed, M.D., as the referring physician. CPT code L1810 describes the item as: "KO, elastic with joints."

14. SORM originally denied reimbursement for the braces Petitioner provided using the denial code "Z1" (preauthorization required). Upon Petitioner's request for reconsideration, SORM added the denial codes "D" (duplicate charge) and "O" (no additional benefit recommended after reconsideration).

15. Petitioner appealed the denial to the Commission, which referred the appeal to an IRO. The IRO found Petitioner used the wrong billing code because it included the modifier "NU" that was not recognized in the Commission's 1996 Medical Fee Guideline.

16. Petitioner timely appealed the IRO decision.

17. Pursuant to the Commission's notice of hearing, all parties appeared or were represented at the hearing held January 6, 2004.

18. The knee braces billed under L1810 were not hinged, adjustable, or fitted but the braces Petitioner provided were.

IV. CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission (Commission) has jurisdiction over this matter pursuant to the Texas Workers' Compensation Act (Act), TEX. LAB. CODE ANN. § 413.031.

2. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The IRO was authorized to hear the medical dispute pursuant to 28 TEX. ADMIN. CODE (TAC) § 133.308.

4. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TAC § 133.308(u).

5. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

6. Petitioner had the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC § 155.41.

7. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

8. Health care includes all reasonable and necessary medical services. TEX. LAB. CODE ANN. § 401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

9. For a carrier to be liable for reimbursement of durable medical equipment, the DME must be preauthorized unless the item costs less than $500. 28 TAC § 134.600.

10. To reimbursed for services or goods, a provider must submit a complete bill including the correct billing codes from the Commission fee guidelines on the Commission approved forms. See 28 TAC §§ 133.1(a)(3)(C), 134.1, and 134.800.

11. A carrier has a duty to communicate with the provider, within seven days of receipt of a bill, to resolve inaccurate or incomplete billings. See 28 TAC 133.300.

12. Within forty-five days of denying a bill, the carrier must provide the provider with an explanation of benefits listing the correct denial of benefits code. 28 TAC § 133.304.

13. With the provider's permission, the insurance carrier can change a billing code and can request additional documentation, which the provider must submit within fourteen days of the request. 28 TAC § 133.301.

14. Each brace was a separate item of DME and cost under the $500 threshold amount for preauthorization under 28 TAC § 134.600, so preauthorization was not necessary for either knee brace.

15. The knee braces provided by Petitioner were not duplicative of the knee braces billed under CPT code L1810 by another provider.

16. Only bases for denial asserted by SORM in its EOB or revised EOB were at issue in this case.

17. Petitioner's use of the modifier “NU” on its bill did not constitute a valid basis for disallowing its claim for reimbursement.

18. Petitioner is entitled to reimbursement for the pair of knee braces provided Claimant and billed under CPT code L1832.

ORDER

It is ORDERED that Houston Premier Durable Medical Equipment is entitled to reimbursement in the amount of $998 by the State Office of Risk Management for two knee braces provided to Claimant.

SIGNED January 21, 2004.

ANN LANDEROS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS