SOAH DOCKET NO. 454-10-3238.M4
DWC MR NO. M4-10-0533-01

INTEGRA SPECIALTY GROUP, P.A.	**§**	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	**§**	**OF**
	§	
INDEMNITY INSURANCE COMPANY	**§**	
OF NORTH AMERICA	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Integra Specialty Group, P.A. (Provider) requested a hearing to contest a medical fee dispute resolution order issued by the Texas Department of Insurance, Division of Workers' Compensation (Division) regarding medical services provided to __. (Claimant). In its order, the Division found that Provider was entitled to reimbursement only in the amount of $2,400 from Indemnity Insurance Company of North America (Carrier). A contested case hearing was conducted, at which Provider appeared through its representative, Aaron Uribe, and Carrier appeared through its attorney, Rebecca Strandwitz. After considering the evidence and arguments presented, the Administrative Law Judge (ALJ) finds that Provider is entitled to additional reimbursement of $2,600 (for a total reimbursement of $5,000, after accounting for prior reimbursement). Therefore, Carrier is ordered to reimburse that additional amount.

Claimant suffered a compensable injury to her back on ___. As part of Claimant's treatment, Provider sought preauthorization from Carrier to provide chronic pain management to Claimant. On September 17, 2008, Carrier preauthorized chronic pain management services in the amount of five times per week, for two weeks, or a total of 10 treatments. The preauthorization letter showed a start date for the services of September 9, 2008, and an end date of October 23, 2008. Provider then provided chronic pain management services to Claimant, but the services were provided between September 22, 2008, and January 14, 2009. After the treatments were rendered, Provider billed Carrier the total amount of $5,000 for the services.

Carrier reimbursed those services provided before October 23, 2008, resulting in total

reimbursement of $2,400 being paid to Provider. Carrier denied reimbursement for the remaining $2,600 on the basis that Provider had exceeded the scope of the preauthorization—which had required the services be ended by October 23, 2008—and had not obtained any additional written preauthorization for the services beyond that date. Provider challenged the denial and requested medical dispute resolution. The Division heard the medical fee dispute, but denied Provider any additional reimbursement, noting that there was no evidence showing that written preauthorization had been obtained to extend the services beyond October 23, 2008. Provider then appealed that decision, resulting in this contested case proceeding.

At the hearing, Provider contended that Carrier had extended its preauthorization to encompass 80 hours of chronic pain management. Provider submitted internal notes showing communications with different Carrier representatives at various times in 2008 whereby Carrier purportedly extended the service amounts and completion dates.[1] Provider also presented a preauthorization approval letter from Carrier dated March 12, 2010, indicating that 10 sessions had been approved to be provided to Claimant through January 16, 2009.[2] Finally, Provider submitted a telephone voice message recording from one of Carrier's employees indicating that their records did show that 80 hours of chronic pain management had been preauthorized for Claimant, to be provided by January 16, 2009. Based upon this evidence, Provider contends that it had properly obtained the necessary preauthorization, and the treatments should have been reimbursed.

Carrier disputed that the Provider obtained appropriate preauthorization. Carrier noted that the letter of March 12, 2008, indicated that 10 sessions of "physical therapy" were approved. Carrier contends this is different than the chronic pain management that was provided. Moreover, Carrier argues that the March 12th letter is not adequate because it did not reflect approval prior to the services being provided. Carrier asserts that the Division's preauthorization rules require written preauthorization be provided. Because the only written preauthorization that existed before the services were provided contained an end date of October 23, 2008, Carrier argues that Provider was

[1] Provider Ex. 1, at 7.

[2] Provider Ex. 1, at 8.

not properly authorized to provide services after that date and should not be reimbursed for them.

After considering the evidence, the ALJ concludes that the preponderant evidence indicates that Provider did obtain the necessary preauthorization for the services and should be reimbursed. Much of Carrier's argument hinges upon its assertion that Provider must have had written preauthorization prior to rendering the services. However, the principle rule relied upon does not require that. Rather, the rule states that "the carrier shall contact the requestor or employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request . . . within three working days of receipt of a request for preauthorization."[3] Thus, oral preauthorization by telephone is permissible. Although the rule goes on to state that the Carrier must send written notification of its decision also,[4] it does not indicate that the Provider is not allowed to rely on the oral notification. Instead, the rule indicates that a failure to comply with the requirements may subject the carrier to an administrative violation, but it does not state that an oral preauthorization approval is invalid.[5]

Therefore, it is clear that Carrier's preauthorization may be shown by something other than just written approval. In this case, the evidence indicates that preauthorization was obtained orally. First, the handwritten notes by Provider reflect various telephone communications with Carrier's representatives, indicating that Carrier approved an extension of the deadline for providing the approved services. These notes reflect the dates of the communications and the specific persons with whom Provider spoke. Moreover, Carrier's own employee confirmed this in her voicemail message to Provider, where she indicated that Carrier's records show the services were authorized through January 16, 2009, and that such approval would have been done as a preauthorization.

Further, the letter of March 12, 2010, from Carrier shows that 80 hours of a chronic pain management program, extending through January 16, 2009, were determined to be medically

[3] 28 TEX. ADMIN. CODE 134.600(i)(1)(emphasis added).

[4] 28 TEX. ADMIN. CODE 134.600(j).

[5] 28 TEX. ADMIN. CODE 134.600(k).

necessary by Carrier.[6] The March 12th letter is identical to the September 17, 2008 preauthorization letter accepted by Carrier, except for the following changes: (1) the March 12th letter reflects the 80 hours of services allowed; (2) under the amount approved, the March 12th letter lists "10 physical therapy" whereas the earlier letter simply had the number 10; and (3) the March 12th letter has an end date of January 16, 2009 for the services. The ALJ agrees with Provider that the inclusion of the phrase "physical therapy" on the March 12th letter was in error. The phrase occurs under the listing of the "amount" approved. However, under the "procedure/description" portion of the letter, Carrier listed "chronic pain management program." And the diagnosis code, reference number and requesting provider are all the same as reflected on the earlier preauthorization letter. Under these circumstances, the ALJ concludes that the March 12th letter is intended to be a revision to the prior preauthorization letter—specifically in light of the other evidence discussed above indicating that the changes shown on the letter were approved by the Carrier orally over the telephone.

In light of the evidence, the ALJ finds that Provider did properly obtain preauthorization from Carrier for the chronic pain management services provided. The services in question were completed prior to the date of January 16, 2009, set by Carrier. Moreover, the services did not exceed the 80 hours approved by Carrier. Therefore, Carrier is liable to reimburse the services in full. Carrier has already reimbursed $2,400 of the services, leaving only $2,600 unpaid. Accordingly, Provider is entitled to additional reimbursement from Carrier in the amount of $2,600. In support of this decision, the ALJ makes the following findings of fact and conclusions of law.

I. FINDINGS OF FACT

1. Employee ___ (Claimant) suffered a compensable injury to her back on ___.

2. On the date of injury, Indemnity Insurance Company of North America (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. As treatment for Claimant's compensable injury, Integra Specialty Group, P.A. (Provider) sought preauthorization from Carrier to provide chronic pain management to Claimant.

[6] Provider Ex. 1, at 8.

4. On September 17, 2008, Carrier preauthorized chronic pain management services in the amount of five times per week, for two weeks, or a total of 10 treatments. The preauthorization letter showed a start date for the services of September 9, 2008, and an end date of October 23, 2008.

5. Carrier later modified its preauthorization and approved 80 hours of chronic pain management to Claimant, with an end date of January 16, 2009.

6. Provider provided 50 hours of chronic pain management services to Claimant between September 22, 2008, and January 14, 2009.

7. After the chronic pain management services were rendered, Provider billed Carrier the total amount of $5,000 for the treatment.

8. Carrier reimbursed Provider only for those services provided before October 23, 2008, resulting in total reimbursement of $2,400 being paid to Provider. Carrier denied reimbursement for the remaining $2,600 on the basis that Provider exceeded the scope of the initial written preauthorization requiring the services to be completed by October 23, 2008.

9. After Carrier denied reimbursement in part, Provider requested medical fee dispute resolution through the Texas Department of Insurance, Division of Workers' Compensation (Division).

10. On __, the Division issued its findings and decision, holding that Carrier was not obligated to reimburse Provider any additional sums.

11. On March 15, 2010, Provider requested a hearing by the State Office of Administrative Hearings (SOAH) to challenge the Division's order.

12. The Division referred the matter to SOAH on March 16, 2010.

13. All parties received adequate notice of not less than 10 days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

14. On June 3, 2010, SOAH Administrative Law Judge Craig R. Bennett held a contested case hearing concerning the dispute at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. At the hearing, Provider appeared through its representative, Aaron Uribe, and Carrier appeared through its attorney, Rebecca Strandwitz. No other persons appeared or participated in the hearing, and the record closed that day.

15. The chronic pain management program at issue in this case was provided for Claimant's compensable injury.

16. The fair and reasonable reimbursement rate for the services provided is $100 per hour.

17. Provider rendered 50 hours of treatment to Claimant.

18. The services provided by Provider to Claimant were properly preauthorized by Carrier.

II. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE §§ 402.073(b), 413.031, 413.0311, and 413.055; and TEX. GOV'T. CODE ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE §§ 2001.051-.052.

3. Provider had the burden of proving by the preponderance of the evidence that it was entitled to reimbursement for the disputed services. 1 TEX. ADMIN. CODE § 155.427; 28 TEX. ADMIN. CODE § 148.14(a).

4. Based on the above findings of fact and conclusions of law, Carrier is liable to Provider for the additional reimbursement of $2,600, and is required to pay that amount to Provider, because the procedures in issue were properly preauthorized, were provided for Claimant's compensable injury, and have not been previously reimbursed by Carrier.

ORDER

THEREFORE, IT IS ORDERED THAT Indemnity Insurance Company of North America is required to pay the sum of $2,600, plus interest, to Integra Specialty Group, P.A. in reimbursement for the chronic pain management program services rendered in this case.

SIGNED June 10, 2010.

CRAIG R. BENNETT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS