MEDICAL CONTESTED CASE HEARING NO. 08083

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A contested case hearing was held on April 22, 2008, to decide the following disputed issue:

1. Whether the preponderance of the evidence is contrary to the Medical Fee Dispute Resolution Findings and Decision that (Provider 1) and (Provider 2) is entitled to be paid $1, 752.69, plus applicable accrued interest, for services provided on August 22, 2006?

PARTIES PRESENT

Carrier appeared and was represented by attorney, PS. (Provider 1) and (Provider 2), Respondent, did not appear and did not respond to a 10-day letter. Claimant did not appear and his appearance was waived by Carrier. The court reporter was JR.

BACKGROUND INFORMATION

Carrier is the petitioner in the instant case, and has the burden of proof. The disputed issue is whether the preponderance of the evidence is contrary to the Medical Fee Dispute Resolution Findings and Decision (MDRO) that the health care provider, (Provider 1) and (Provider 2), is entitled to be paid $1,752.69, for services provided on August 22, 2006.

In evidence as Carrier Exhibit B is the Medical Fee Dispute Resolution Findings and Decision. In Part II of the decision it states:

> Requestor's Position Summary (Table of Disputed Services): "Insurance company is denying our claim incorrectly. They are denying us, the anesthesiologist, for unnecessary medical treatment but they did pay the surgeon which make any sense [sic]. Sent reconsideration and the Ins. Co. never responded."

In Part II of the decision, the "Principal Documentation" is noted as follows:

1. DWC 60 package
2. Total Amount Sought - $1,752.69
3. CMS 1500s
4. EOBs
5. Preauthorization Letter for hospital stay

In Part III of the decision, it was noted, "No response was received from the Respondent."

In Part IV of the decision, Summary of Findings, the following information was provided:

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V References	Amount Ordered
8-22-06	00670-P3-AA	50(889)	1, 2, 3	$1,752.69

In Part V of the decision, Review of Summary Methodology and Explanation, it was stated: Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer," and "889-This service was not considered reasonable or necessary for the medical causality problem. $0.00."

2. Modifier "P3" indicates that this is a patient with mild systemic disease. Modifier. "AA" indicates that the anesthesia services were personally performed by the anesthesiologist.

3. The anesthesiologist services cannot be denied for unnecessary medical treatment when the surgery and the hospital stay were preauthorized. The Respondent has reimbursed the surgeon's bill. Per Rule 134.600 (c)(1)(B) "The carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care."

4. Recommend reimbursement per Rule 134.202(c)(1). Calculation is as follows:

   CPT code 00670 has a base unit value of 13. The CMS 1500 shows 335 minutes.

   37 units x $47.37 (conversion factor for 2006) = $1,752.69

In Part VII, Division Decision, it reads as follows:

> Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code section 413.031, the Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the requestor the amount of $1,752.69 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

The Decision was signed on November 5, 2007, by DDA, Medical Fee Dispute Resolution Officer. The Carrier appealed and the CCH was heard on April 22, 2008.

Carrier as the Petitioner has the burden of proof by a preponderance of the evidence. Carrier offered no witnesses at the April 22, 2008, CCH, and only offered exhibits and arguments. Carrier stated that the last time it had paid for any medical treatment in this case was in January of 2006, and that subsequent treatment was being denied on the basis of the RME doctor's opinion. Carrier argued that surgery in 2006 was not pre-authorized by the insurance carrier in

the case, and the carrier had not paid for any medical costs or ancillary costs associated with that surgery. In Carrier Exhibit C are contained Carrier's "Non Certified" Case Summaries for January 6, 2005, January 31, 2005, and April 27, 2005. The January 6, 2005, Case Summary indicated that on January 6, 2005, Sh at (Institute) was given verbal notice of the adverse determination for the non-certified lumbar fusion to L4-5, L5-S1. The January 31, 2005, Case Summary Report indicates that on January 31, 2005, Sh at (Institute) was given verbal notice of the denial for the non certified lumbar fusion. The April 27, 2005, Case Summary Report indicated that on April 27, 2005, a voice mail message was left with B of the non certification and denial for the proposed lumbar fusion L4-S1 vs. Fusion L5-S1 w/disk replacement.

What is troubling about this case is that the Medical Fee Dispute Resolution Findings and Decision document that the "Principal Documentation" included CMS 1500s, EOBs, and a Preauthorization Letter for the hospital stay, and yet Carrier argued that it never pre-authorized the spinal surgery. Carrier was the only party who appeared at the CCH, and Carrier has the burden of proof.

Although Carrier sought to carry its burden of evidence by argument and submitting prior denials, the evidence remained that it could not explain nor present any credible evidence to overcome the evidence documented in the Medical Fee Dispute Resolution Findings and Decision. When the Carrier attorney was specifically asked by the hearing officer how he could explain the fact that there was documentation considered by the medical fee dispute resolution officer, which included a preauthorization letter for hospital stay, Carrier attorney simply responded that he could not. The more credible evidence established that the Carrier originally denied the health care provider's request for payment as not deemed a medical necessity, and that the service was not considered reasonable or necessary for the medical causality problems by the Carrier. (See Carrier B-3). When the Medical Fee Dispute Resolution Officer reviewed all of the documentation, there was a "Preauthorization Letter for hospital stay." (See Carrier Exhibit B-2).

Medical necessity was not at issue in this hearing, the issue was, "Was the preponderance of the evidence was contrary to the Medical Fee Dispute Resolution Findings and Decision." Carrier's position and basis for its argument at the CCH was that the surgery that Claimant underwent in August 2006 was not pre-authorized and was not undertaken for treatment associated with the compensable injury. Carrier has failed to meet its burden of proof.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

2. Claimant sustained a compensable injury on _____, while employed by (Employer).

3. (Provider 1) and (Provider 2) provided health care services to Claimant on August 22, 2006, in the amount of $1,752.69.

4. The anesthesia services were personally performed by the anesthesiologist on August 22, 2006.

5. Carrier pre-authorized the surgery and the hospital stay.

6. Carrier originally sought to deny the health care provider's bill for anesthesia services as unnecessary, yet reimbursed the surgeon's bill for the surgery.

7. Per Rule 134.600(c)(1)(B), Carrier is liable for all reasonable and necessary medical costs relating to the health care that was approved prior to providing the health care.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the Medical Fee Dispute Resolution Findings and Decision that (Provider 1) and (Provider 2) is entitled to be paid $1,752.69, plus applicable accrued interest, for services provided on August 22, 2006.

DECISION

The preponderance of the evidence is not contrary to the Medical Fee Dispute Resolution Findings and Decision that (Provider 1) and (Provider 2) is entitled to be paid $1, 752.69, plus applicable accrued interest for services, provided on August 22, 2006.

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act, and the Commissioner's Rules.

The true corporate name of the insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is:

COMPANY
(ADDRESS)
(CITY), TX (ZIP CODE)

Signed this 5th day of May 2008

CHERYL DEAN
Hearing Officer