MEDICAL CONTESTED CASE HEARING NO. 10019
M4-09-7105-01

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.

ISSUES

A contested case hearing was held on September 11, 2009 to decide the following issue:

1. Is the preponderance of the evidence contrary to the decision of Medical Review that Petitioner is not entitled to additional reimbursement in the amount of $780.75 plus applicable accrued interest for date of service of _____?

PARTIES PRESENT

Claimant did not appear, and her appearance was waived by the parties. Petitioner appeared and was represented by JG, lay representative. Respondent/Self-Insured appeared and was represented by PS, attorney.

BACKGROUND INFORMATION

This case is governed by Division Rule 134.402, ambulatory surgical center (ASC) fee guidelines. On _____ Claimant underwent surgery at the Petitioner ASC facility. In dispute was $780.75 billed under CPT code 26340 for manipulation of fingers under anesthesia. The Medical Fee Dispute Resolution Findings and Decision determined that Petitioner was not entitled to additional reimbursement for this service.

Rule 134.402(e)(3) provides:

(3) If a service is not included on the ASC List of Medicare Approved Procedures or listed in subsection (e)(2) of this section, the insurance carrier, health care provider, and ASC may agree to an ASC setting as follows:
  (A) The agreement may occur before, during, or after preauthorization.
    (i) A preauthorization request may be submitted for an ASC setting only if an agreement has already been reached and a copy of the signed agreement is filed as part of the preauthorization request.
    (ii) A preauthorization request or approval for a non-ASC facility setting may be revised to an ASC setting by written agreement of the carrier and the health care provider during or after preauthorization.
  (B) The agreement between the carrier and the ASC must be in writing, in clearly stated terms, and include:
    (i) the reimbursement amount;
    (ii) any other provisions of the agreement; and
    (iii)names, titles, and signatures of both parties with dates.
  (C) Copies of the agreement are to be kept by both parties.

(D) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

It was undisputed that CPT code 26340 was not on the ASC list of Medicare approved procedures for the date of service and is not listed in Rule 134.402(e)(2). Petitioner argued the service in question was pre-authorized, and the pre-authorization determination letter constituted an agreement within the meaning of subsection (e)(3). It did not in several respects. The reimbursement amount was not stated as required by subsection (e)(3)(B)(i), and the letter did not contain the names, titles, and signatures of both parties with dates as required by subsection (e)(3)(B)(iii). Moreover, subsection (e)(3)(A)(1) requires that a copy of the signed agreement be filed with the pre-authorization request. A pre-authorization determination letter obviously could not comply with this part of subsection (e)(3). There was no showing of a purported written agreement apart from this letter.

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

FINDINGS OF FACT

1. The parties stipulated to the following facts:

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

   B. On _____ Claimant was the employee of (SELF-INSURED).

   C. On _____ Claimant sustained a compensable injury.

   D. Medical Review determined that Petitioner is not entitled to additional reimbursement for the services involved in this dispute.

2. Self-Insured delivered to Petitioner a single document stating the true corporate name of Self-Insured, and the name and address of Self-Insured's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The disputed fee was billed under CPT code 26340; CPT code 26340 was not on the ASC list of Medicare approved procedures for the date of service, _____, and is not listed in Rule 134.402(e)(2).

4. Petitioner put forward a pre-authorization determination letter as an agreement complying with the requirements of Rule 134.404(e)(3); the letter does not meet the requirements of the rule.

5. The preponderance of the evidence is not contrary to the decision of Medical Review that Petitioner is not entitled to additional reimbursement in the amount of $780.75 plus applicable accrued interest for date of service of _____.

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 of the Texas Department of Insurance, Division of Workers' Compensation.

3. The preponderance of the evidence is not contrary to the decision of Medical Review that Petitioner is not entitled to additional reimbursement in the amount of $780.75 plus applicable accrued interest for date of service of _____.

DECISION

Petitioner is not entitled to additional reimbursement in the amount of $780.75 plus applicable accrued interest for date of service of _____.

ORDER

Self-Insured is not liable for the benefits that were at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021 of the Act.

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

DO, SUPERINTENDENT
(STREET ADDRESS)
(CITY), TEXAS (ZIP CODE)

Signed this 11th day of September, 2009.

Thomas Hight
Hearing Officer