SOAH DOCKET NO. 453-04-3673.M4

EAST HARRIS COUNTY ORTHOPEDICS, Petitioner	§	**BEFORE THE STATE OFFICE**
VS.	§	**OF**
CITY OF HOUSTON, Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

East Harris County Orthopedics (Provider) challenges the denial of reimbursement by the City of Houston (Carrier) for a lumbar laminectomy with spinal fusion. Carrier had denied reimbursement based on Provider's failure to secure preauthorization for procedures ultimately performed. The Administrative Law Judge (ALJ) concludes the procedures performed by Provider differed from those preauthorized by the Texas Workers' Compensation Commission (Commission) in conjunction with the second opinion process. Consequently, reimbursement is denied.

I. STATEMENT OF THE CASE

Notice and jurisdiction, which were not disputed, are addressed in the Findings of Fact and Conclusions of Law. Administrative Law Judge (ALJ) Gary Elkins convened a hearing on June 7, 2004. Both Petitioner and Respondent appeared at the hearing. After the parties filed post-hearing briefs, the hearing closed on June 11, 2004.

II. DISCUSSION

A. Background and Parties' Positions

The issue in this case is whether and to what extent a provider's variance from the procedures for which it sought and received preauthorization disqualifies it from reimbursement for the services provided. On December 20, 2001, Provider filed a TWCC-63 (Recommendation for Spinal Surgery) in which it sought preauthorization for a lumbar laminectomy under CPT Code 63047 and a fusion under CPT Code 22630 at spine level L3-L4. The second opinion process in effect at the time required a second concurring opinion, if requested, when spinal surgery was proposed. Based on the Commission's conclusion that Carrier had failed to successfully pursue a second opinion, it preauthorized the proposed procedure.

Provider proceeded with surgery in August 2002 but billed Carrier under different CPT codes, 63042 (lumbar laminotomy) and 22625 (lateral transverse arthrodesis), than were specified in its preauthorization request. Carrier denied reimbursement for these services because they were not a part of Provider's preauthorization request.

In support of its argument that the services provided were preauthorized, Provider argues the following:

- It sought preauthorization in accordance with § 133.206(e)(1) of the Commission's rules.

- Carrier waived its right to a second opinion, as determined by the Commission in its letter of preauthorization. Consequently, Carrier is liable for the cost of the spinal surgery as contemplated in § 133.206(b)(1)(B) of the Commission's rules.

- The surgical procedures for which Provider sought preauthorization were consistent with and sufficiently inclusive of those procedures actually performed, in accordance with Item 34 of Form TWCC-63.

In support of its argument that the pre-authorization requirements placed on the surgeon were not met in this case, Carrier argues the following:

- Item 34 on the back of the Form TWCC-63 requires a surgeon to specify the recommended surgical procedure using CPT codes and descriptions when seeking preauthorization. The CPT Codes Provider billed following the surgery were wholly different from those forming the bases of the preauthorization and, thus not preauthorized.

- Despite the Commission's conclusion that Carrier had waived its right to a second opinion, resulting in preauthorization for the procedure, Carrier had properly arranged for a second opinion evaluation as required by ' 133.206 but the injured worker failed to attend the evaluation appointment. Consequently, the Commission erred in granting preauthorization.

B. Analysis and Conclusion

1. Second Opinion Process

The only evidence relating to the Carrier's request for and arrangement of a second opinion evaluation is found in a March 5, 2002, letter in which the Commission granted preauthorization. In the letter the Commission concluded that Carrier "failed to respond and/or to schedule a second opinion appointment . . . ." Carrier failed in its attempt to paint the conclusion as erroneous. Although it presented argument at the hearing and in its post-hearing brief describing how it had complied with the second opinion procedures, it presented no evidence supporting the assertion.

2. Surgical Procedures Authorized Versus Those Billed

Not only do the CPT codes billed by Provider differ from those listed in its request for preauthorization, the Operative Report for the surgery confirms that the surgical procedures performed differ substantially from those requested and preauthorized. While Provider's request for preauthorization listed a laminectomy and a fusion at the L3-L4 level of the spine, the surgical procedures performed far exceeded the request:

- bilateral laminectomies at levels L2-L3, L3-L4, L4-L5, L5-S1, and S1-S2 with foraminotomies at L2, L3, L4, L5, S1, and S2;
- lateral transverse fusion at levels L3-L4, L4-L5, L5-S1, and S1-S2; and
- posterior lateral facet fusion at L3-L4, L4-L5, L5-S1, and S1-S2.

Other surgical procedures and services were also provided, including exploration of a fusion mass; excision of pseudoarthrosis; excision of a herniated lumbar disc at level L3-L4; excision of spinous processes; provision of bilateral instrumentation; performance of a fat graft; closure of a seroma formation; and scar revision with skin and subcutaneous adjacent tissue transfer.

The ALJ agrees with Provider's argument that it would be unreasonable to require a surgeon to anticipate, and thus include in a request for preauthorization, every surgical procedure and ancillary service that might be deemed medically necessary once the surgery has begun. The surgeon may reasonably discover problems not revealed during diagnostic testing. Nevertheless, the ALJ concludes Provider far exceeded such a scenario when he not only billed for different procedures than those preauthorized but also extended the fusions and laminectomies to include several levels of the spine that were not included in the preauthorization request. Consequently, as set forth in the Findings of Fact and Conclusions of Law, Provider is not entitled to reimbursement for the billed services.

III. FINDINGS OF FACT

1. An injured worker (Claimant) suffered a compensable injury on ___.

2. At the time of Claimant's injury, his employer held workers' compensation insurance coverage through the ___ (Respondent).

3. On December 20, 2001, East Harris County Orthopedics (Provider) filed a TWCC-63 (Recommendation for Spinal Surgery) in which it sought preauthorization for a lumbar laminectomy under CPT Code 63047 and a fusion under CPT Code 22630, both to be performed at spine level L3-L4.

4. On March 5, 2002, the Texas Workers' Compensation Commission (Commission) granted preauthorization for the requested procedures.

5. Because a second opinion doctor never evaluated Claimant in order to provide a second opinion, there was no concurrence from a second opinion doctor.

6. On August 8, 2002, Provider performed the following surgical procedures based on the Commission's March 5, 2002, preauthorization:

    a. bilateral laminectomies at levels L2-L3, L3-L4, L4-L5, L5-S1, and S1-S2 with foraminotomies at L2, L3, L4, L5, S1, and S2 bi-laterally;
    b. lateral transverse fusions at levels L3-L4, L4-L5, L5-S1, and S1-S2;
    3. posterior lateral facet fusions at L3-L4, L4-L5, L5-S1, and S1-S2;
    4. exploration of a fusion mass;
    5. excision of pseudoarthrosis;
    6. excision of a herniated lumbar disc at level L3-L4;
    7. excision of spinous processes;
    8. provision of bilateral instrumentation;
    9. a fat graft;
    10. closure of seroma formation; and
    11. scar revision with skin and subcutaneous adjacent tissue transfer.

7. Provider billed Carrier for the services listed in Finding of Fact No. 6 under CPT Codes 63042, 22625-51, 22650, 22842, 22852, 22830, 15734, and 14300.

8. Carrier denied reimbursement for the billed services as not having been preauthorized.

9. Provider filed a request for medical dispute resolution on February 3, 2003.

10. On January 23, 2004, a medical dispute resolution officer with the Commission's Medical Review Division (MRD) concluded Provider's request for reimbursement should be denied

because it had not listed the billed CPT codes in its preauthorization request.

11. Based on the MRD decision, Provider timely requested a hearing before SOAH.

12. Notice of the hearing was mailed to the parties February 20, 2004. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

13. Administrative Law Judge (ALJ) Gary Elkins convened a hearing on June 7, 2004. Both Provider and Carrier appeared at the hearing. The hearing closed on June 11, 2004.

14. In its request for preauthorization, Provider did not include any of the services or CPT codes for which it seeks reimbursement.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding pursuant to ' 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

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

3. Provider bears the burden of proof in this matter. 28 TEX. ADMIN. CODE (TAC) ' 148.21(h).

4. The requested procedures were not deemed appropriate as a result of a second opinion.

5. The surgical procedures performed by Provider were both different from and far exceeded those described in its request for preauthorization and for which 28 TAC § 133.206 would hold a carrier responsible.

6. Provider failed to obtain preauthorization for the services provided, as required by 28 TAC ' 134.600(h)(3).

7. Based on the foregoing Findings and Conclusions, Provider is not entitled to reimbursement for the spinal surgery and related services provided to Claimant on August 8, 2002.

ORDER

IT IS ORDERED that East Harris County Orthopedics is not entitled to reimbursement for

the spinal surgery and related services provided to Claimant on August 8, 2002.

Signed August 10, 2004.

GARY W. ELKINS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS