SOAH DOCKET NO. 454-08-4148.M4
TWCC MR NO. M5-08-0854-01

JOHN C. MILANI, M.D., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
ACE USA/ESIS, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

John C. Milani, M.D., requested a hearing to contest a decision by the Texas Department of Insurance, Workers Compensation Division (Division) Medical Review Division (MRD), which determined that the Division had no jurisdiction over his medical fee dispute (dispute) with ACE USA/ESIS (Carrier). MRD based its decision on its finding that Dr. Milani had entered into a network contract with Carrier and on a rule that authorizes it to dismiss a dispute for health care services provided pursuant to a private contractual fee arrangement.[1] However, neither party agreed or argued that Dr. Milani has a private contractual arrangement with Carrie. Carrier denied Dr. Milani's claim based on its determination that the services he provided to an injured worker (Claimant) required preauthorization, but that he did not obtain preauthorization. Dr. Milani's staff testified that Carrier preauthorized the services. The Administrative Law Judge (ALJ) finds that Carrier should pay Dr. Milani for his services.

I. PROCEDURAL HISTORY

A hearing convened and closed in this case on September 29, 2008, before the undersigned ALJ at the State Office of Administrative Hearings (SOAH), Austin, Texas. Dr. Milani appeared through Office Administrator Judith Hammett. Carrier was represented by Attorney Peter L. Macaulay. Because there were no issues concerning notice or jurisdiction, those matters are stated in the Findings of Fact and Conclusions of Law without further discussion here.

[1] 28 TEX. ADMIN. CODE (TAC) § 133.307(e)(3)(F).

II. DISCUSSION

A. Background

The Claimant sustained an injury to her neck on ____. Her doctor referred her to Dr. Milani for a cervical-spine surgery evaluation on July 31, 2007. Dr. Milani requested preauthorization for the surgery in August 2007, which Carrier denied.[2] Carrier found that Claimant had reached maximum medical improvement.

On December 7, 2007, after seeing Claimant again, Dr. Milani requested preauthorization for an operation that was described by Carrier's peer reviewer, Rolando Saenz, M.D., as "Anterior C5-6, C6-7, cage implant, anterior plate/screws, allograft, fluoroscopy" (the surgical procedure). According to Ms. Hammett, Dr. Milani's office (the office) received verbal approval for the surgical procedure on December 17, 2008, from an assistant to Carrier's adjuster. Dr. Milani performed the operation shortly afterward on December 19, 2007. Ms. Hammet said Dr. Milani has continued to see Claimant, including as recently as July 1, 2008, and she is doing well.

Carrier denied Dr. Milani's claim for the surgical procedure. However, it did pay $672.16 for his physician's assistant's fee.[3] At the hearing, Carrier pointed out that it mistakenly believed it was paying pursuant to a network agreement and it has now requested a refund.[4]

The Division's rules at 28 TEX. ADMIN. CODE (TAC) § 134.600(c) provide that an insurance carrier is liable for all reasonable and necessary medical costs relating to health care listed in subsections (p) and (q) of the rule only in the case of an emergency; preauthorization of any health care listed in subsection (p) that was approved prior to the provision of the care; a concurrent review of health care listed in subsection (q) that was approved prior to the care being provided; when ordered by the Commissioner; or, per subsection (r), when voluntary certification was requested and payment agreed on prior to the provision of health care not listed in subsection (p). Subsection (p) requires preauthorization for several categories of non-emergency health care, including hospital

[2] Ms. Hammett acknowledged that Dr. Milani knew he had missed the deadline for appealing Carrier's denial of the surgery request.

[3] Appellant's Ex. 1 at 30-31.

[4] Carrier Ex. 1 at 16. Carrier speculated that MRD may have gotten its idea that this dispute involved a private contractual fee arrangement from a record of payment to the physician's assistant based on a network contract.

admissions and durable medical equipment.

B. Party Evidence and Positions

The issue to be determined in the case is whether Dr. Milani proved that Carrier preauthorized the surgical procedure as medically necessary.[5] If he did, he should be paid because a failure to seek preauthorization is the only ground Carrier cited as a reason for denying the claim.[6] Under Rule 134.600(c), Carrier is not required to pay Dr. Milani if he did not obtain preauthorization.[7] The following is a description and analysis of the evidence on this issue.

1. Dr. Milani

At the beginning of the hearing, three of Dr. Milani's office workers were sworn in to testify, including office administrator Judith A. Hammett, medical assistant Rita Chandler, and billing department employee Jeanene Gray.

According to Ms. Chandler, when the first surgical request was denied, Claimant was sent back to her referring doctor for conservative treatment. Ms. Hammett testified Carrier approved and Claimant received epidural steroid injections and additional testing. She said that, when Claimant's pain kept increasing, the office saw her again in December 2007, after which it put in a second request for surgery. Ms. Hammett testified that the physician's note and all diagnostic records showing Claimant's condition were submitted to Carrier when it requested surgery a second time on December 7, 2007.

Ms. Hammett testified that Ms. Chandler received a verbal approval for the surgical procedure on December 17, 2007, from a Carrier employee who, according to Ms. Chandler, described herself as the assistant to Carrier's adjuster. This person said she was filling in for the

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[5] As the party seeking relief, Dr. Milani has the burden of proof. 28 TAC § 148.14.

[6] Carrier Ex. 1 at 8-9.

[7] 28 TAC § 134.600(c).

regular adjuster who was on sick leave.[8] Ms. Hammett said that Carrier's peer reviewing physician Dr. Saenz said the surgical procedure was medically unnecessary at first, but after Dr. Milani talked to him, he changed his opinion and said he would amend his report to approve the procedure. When it got word of the verbal approval, the office assumed that Dr. Saenz had followed through and amended his report.

Ms. Chandler testified that the adjuster's assistant told her the surgical procedure was approved and the surgery could go forward. She said the assistant said she could not give a preauthorization number until the approval letter was issued.

Ms. Hammett said the office noted the verbal approval on the hospital's scheduling sheet. She said the hospital will usually check with the insurer when that notation is made, but she does not know whether it did so on this occasion.

Ms. Hammett testified the office assumed everything was okay when it received payment for the physician assistant's fee on February 6, 2008. They called Carrier on February 12, 2008, to inquire about the surgeon's fee, but Carrier said it had not received the claim. She said this was a time when electronic claims were in the beginning stages and a lot of insurers were having problems. They subsequently heard from Carrier's adjuster, who she identified as a "Debbie Larson."[9] Ms. Larson said there had been no verbal approval for the surgical procedure and denied having an assistant.

Ms. Hammett said she "did inquiries" after talking to Ms. Larson by calling and talking to Carrier's nurse case manager at the time. According to Ms. Hammett, the nurse case manager said, "[T]his is not unusual," but would not elaborate further. The nurse case manager verified that the adjuster had been out on medical leave and there had been an assistant adjuster. She would not give the assistant's name. Ms. Hammett said she knows that Carrier maintains a call log. She said the call should be on the log.

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[8] On its Table of Disputed Services, the office stated the following in its rationale: "Adjuster was out on sick leave. Peer review physician initially denied surgery then spoke with Dr. Milani 12/17/07 Monday afternoon. Rita from our office received call from adjuster's assistant saying schedule surgery and new letter will be sent after addendum is done. Surgery scheduled. No addendum done—letter faxed looked like surgery was under certified heading, no non-certified heading. . . . ." (Emphasis in original.) Appellant Ex. 1 at 10.

[9] In an affidavit submitted with its pre-filed documents, Carrier's adjuster was identified as Beverly Weygandt. (Carrier Ex. 1 at 25.)

Ms. Hammett testified the office thought that a December 14, 2007 letter from Carrier that was an approval because a "1" was placed under the words "Certified Quantity," with no comment under the words "Non-Certified Quantity."[10] She cited a previous disapproval by the Carrier where it had placed "0" under the words, "Certified Quantity" and "1" under the words "Non-Certified Quantity."[11] She understands now that the letter actually did not approve the surgical procedure—Dr. Saenz's Review Summary attached to the letter states, "Non-Certified."[12]

Ms. Hammett acknowledged that Dr. Milani sees about 200 total patients in the average month, although he probably saw only about 150 in December 2007 because of the holidays. He will see seven or eight new patients on a full day and four or five on a half day. He has about 14 surgeries per week and about 20 to 30 post-surgery follow-ups per week. The office deals with 20 or 30 different insurance companies.

In closing, Ms. Hammett asserted that the office has been doing workers' compensation work for more than 20 years and is very conservative about performing surgeries without appropriate evidence of preauthorization. It is not their routine to do surgeries on verbal preauthorization alone, but, as the patient advocate, they realize that sometimes a patient's condition requires early treatment to avoid suffering. In this case, the Claimant wanted to have the surgery before the Christmas holidays. They accepted the verbal authorization in good faith. This is the first workers' compensation contested hearing the office has ever participated in and is the first time the office has been "burned."

2. Carrier

Carrier introduced into evidence an affidavit from adjuster Beverly Weygandt, who said she is an adjuster for ESIS Workers' Compensation Claims Center (Center) and is familiar with the workers' compensation claim file submitted for Claimant. According to Ms. Weygandt, the file is maintained at the Center. She said there are no adjuster assistants at the Center, only adjusters and telephone operators. The telephone operators do not make decisions regarding the administration of

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[10] Appellant Ex. 1 at 4.

[11] Carrier Ex. 1 at 11.

[12] Carrier Ex. 1 at 11.

workers' compensation claims. The Center does not give verbal approvals for surgery.

Ms. Weygandt said any action taken by an adjuster is documented in adjuster notes. She has reviewed all adjuster notes and materials contained in Claimant's file and there is no adjuster note on December 14, 2007, documenting a request for the surgical procedure. There is no note indicating that anyone from Dr. Milani's office contacted the Center for a verbal approval of the surgical procedure on December 17, 2007, or at any other time. No one from the Center ever contacted Dr. Milani's office to approve medical services that were performed on December 19, 2007, or any other medical procedures. Ms. Weygandt said, under the circumstances of this case, no one at the Center would override the non-certification decision submitted by the Center on December 14, 2007.

In closing, Carrier pointed out that the physician-assistant payment was made by mistake. Carrier disputed Dr. Milani's contention that Dr. Saenz changed his position. It cited the fact that Dr. Saenz was already very definite in saying the surgical procedure should be non-certified. Carrier pointed out that Dr. Milani's office deals with an exceptionally large number of cases and it is not hard to imagine how an office employee could have gotten this case confused with another one. It cited Division rules indicating that the surgical procedure would have required preauthorization for Dr. Milani to receive reimbursement. Carrier cited Ms. Weygandt's affidavit as indicating that Carrier does not verbally preauthorize the type of procedure at issue in this case.

C. Analysis

The ALJ finds the weight of preponderant evidence is that Carrier gave a verbal approval for the procedure. Clearly, Carrier would not have given verbal approval under ordinary circumstances. However, the circumstances in this case were not ordinary because evidence from two witnesses indicates that the adjuster was out on sick leave. Ms. Weygandt did not deny this in her affidavit and did not address whether Ms. Larson was out on sick leave. To find that Carrier did not verbally authorize the surgery, it is necessary to disbelieve three different people in Dr. Milani's office—Ms. Chandler, Ms. Hammett, and Dr. Milani himself, who, according to Ms. Hammett, said he persuaded Dr. Saenz to change his mind. Ms. Chandler testified under oath that she received a verbal approval. Carrier's theory that she might have gotten this case mixed up with one of the many other cases that came to the office in December 2007 might seem plausible, except that her testimony was corroborated by Ms. Hammett's sworn testimony concerning her conversation with the nurse case manager, who confirmed that the regular adjuster had been out on sick leave and that

there was an assistant adjuster. The nurse case manager's statement that the situation was "not unusual" implies that there may have been other similar problems.

Dr. Milani's version of events is supported by Carrier's December 14, 2007 letter, which is somewhat ambiguous on the issue of preauthorization. Based on Carrier's August denial, it appears that Carrier's method of showing a requested procedure as "certified" or "non-certified" is to place a "1" or other number under one or the other of those headings. Its December 14 letter to the office contained a "1" under the "certified" designation. It is conceivable that Carrier intended to indicate the procedure was certified, but mistakenly attached Dr. Saenz's letter indicating non-certification.

In summation, the preponderant evidence is that the office received a verbal approval for the surgical procedure. On that basis, Carrier will be ordered to pay Dr. Milani for the surgery.

III. FINDINGS OF FACT

1. John C. Milani, M.D., requested a hearing to contest a decision by the Texas Department of Insurance, Workers Compensation Division (Division) Medical Review Division (MRD), which determined that the Division had no jurisdiction over his medical fee dispute (dispute) with ACE USA/ESIS (Carrier).

2. MRD based on its determination on a finding that Dr. Milani had entered into a network contract with Carrier and on a rule that authorizes it to dismiss a dispute for health care services provided pursuant to a private contractual fee arrangement.

3. Neither party argued that Dr. Milani has a private contractual arrangement with Carrier.

4. Carrier denied Dr. Milani's claim based on its determination that the services he provided to an injured worker (Claimant) required preauthorization, but that he did not obtain preauthorization.

5. Claimant sustained an injury to her neck on ____.

6. Claimant's doctor referred her to Dr. Milani for a cervical-spine surgery evaluation on July 31, 2007.

7. In August 2007, Dr. Milani requested preauthorization for surgery for Claimant, which Carrier denied.

8. Carrier found that Claimant had reached maximum medical improvement.

9. Claimant was referred back to her referring doctor, after which Carrier approved epidural steroid injections and additional testing.

10. On December 7, 2007, after seeing Claimant again when her pain had continued to increase, Dr. Milani requested preauthorization for an "Anterior C5-6, C6-7, cage implant, anterior plate/screws, allograft, fluoroscopy" (the surgical procedure).

11. Carrier at first denied the surgical procedure based on an opinion from its peer reviewing physician, Rolando Saenz, M.D.

12. After Dr. Milani talked to Dr. Saenz, Dr. Saenz agreed to change his position and approved the surgical procedure.

13. Dr. Milani's office received a verbal approval from Carrier's assistant adjuster on December 17, 2007.

14. On the basis of the verbal approval, Dr. Milani performed the surgical procedure on December 19, 2007.

15. Dr. Milani has not been paid for the surgical procedure.

16. All parties received notice of the hearing that contained a statement of the time, place, and nature of the hearing; 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.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.052.

3. Carrier should pay Dr. Milani's surgical fee.

ORDER

IT IS THEREFORE ORDERED that ACE USA/ESIS pay John C. Milani, M.D., for the surgical procedure performed on Claimant on December 19, 2007, plus any applicable interest.

SIGNED November 3, 2008.

JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS