SOAH DOCKET NO. 454-09-1240.M4
DWC MR NO. M4-04-7176-01

TRANSCONTINENTAL INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
PETITIONER	§	
	§	**OF**
V.	§	
	§	
ERIC SCHEFFEY, M.D.,	§	
RESPONDENT	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Transcontinental Insurance Company (Carrier) 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 _____ (Claimant). In its order, the Division found that Eric Scheffey, M.D. (Provider) was entitled to reimbursement in the amount of $10,593.50 from Carrier. At the hearing, Provider appeared telephonically, through his authorized representative, and Carrier appeared in-person through its attorney. After considering the evidence and arguments presented, the Administrative Law Judge (ALJ) finds that Provider is entitled to $3,400.00 in additional reimbursement. Therefore, Carrier is ordered to reimburse that amount only, and not the amount previously ordered by the Division.

This case is fairly straightforward. On or about May 9, 2003, Provider sought and obtained preauthorization from Carrier to perform a "Lumbar Laminotomy fusion Inst. L5-S1," with CPT codes 63042, 22630, and 22842, on Claimant. The procedure was performed on May 20, 2003. After the surgery, Provider billed for additional codes and procedures that were not specifically listed in the preauthorization request as part of the same surgery. Carrier initially denied reimbursement for all procedures, but later reimbursed Provider the sum of $5,302.00 for some of the procedures. For the unreimbursed procedures, Carrier denied payment on the basis that the procedures were not preauthorized, not medically necessary, and/or were global to other procedures.

Provider contends that the preauthorization for the laminotomy should also cover the unreimbursed procedures, because the procedures were directly related to the preauthorized procedures, were medically necessary, and were not global to any reimbursed procedures. However, Provider presented no expert testimony on this matter, but rather relied upon the documentation in

the record. In contrast, Carrier presented the testimony of Marvin Van Hal, M.D., who testified that the unreimbursed procedures were entirely distinct procedures, for which preauthorization would be necessary. For example, the unreimbursed procedures included surgery at different levels of the spine other than that lone level (L5-S1) preauthorized, and included procedures (e.g., CPT codes 63030, 63035, and 20975) that went beyond the scope of the procedures preauthorized. Dr. Van Hal conceded that additional procedures can sometimes be justified based upon findings discovered during the course of the surgery. However, he indicated that the surgery notes in this case do not contain any justification for why the additional procedures would have been necessary or appropriate based upon findings that arose during the surgery. Further, he testified that pre-surgery diagnostic tests do not indicate any problems that would have warranted the additional procedures. Thus, Dr. Van Hal testified that the additional procedures appeared unnecessary and, even if they were necessary, were required to be preauthorized before being performed.

On the record before him, the ALJ concludes that Provider should not be reimbursed for the procedures which were not preauthorized. Preauthorization is required for spinal surgeries like that involved here, and for the additional procedures attendant to such spinal surgeries. In this case, the preauthorization was for surgery at one level and only for certain procedures. Provider clearly exceeded that preauthorization by treating additional levels, and by the additional services provided and billed. Although Provider contends that the procedures should be considered within the scope of the preauthorization, the only expert evidence in the record is to the contrary. Without expert evidence or other authority to support his position, Provider's arguments fail. Accordingly, given that the undisputed expert testimony in the record is that the unreimbursed procedures were not necessary and were separate and distinct procedures for which preauthorization is required (but such preauthorization was not obtained), the ALJ concludes that Carrier is not required to reimburse them. However, one of the procedures for which reimbursement was denied is "instrumentation" under CPT code 22842. Both this code and this procedure were previously preauthorized by Carrier. Dr. Van Hal had no explanation for why the procedure was not reimbursed. Even Carrier's attorney conceded at the hearing that procedure should have been reimbursed. Provider billed $5,983.00 for the procedure, but the maximum allowable reimbursement (MAR) is $3,400.00. Therefore, since preauthorization was obtained for this procedure, the ALJ finds that Provider is entitled to reimbursement in the amount of $3,400.00 for it.

Carrier argues that, when it previously reimbursed Provider $5,302.00 for the surgery, it erroneously reimbursed $1,902.00 for procedures billed under CPT codes 22625 and 22650, which had not been preauthorized. Carrier contends that any order of reimbursement in this case should include an offset for those amounts erroneously reimbursed. Accordingly, Carrier argues that the maximum amount it would owe Provider in this case is $1,498.00.[1]

In support of its request, Carrier cites to TEX. LABOR CODE § 413.016(a), which states "[t]he division shall order a refund of charges paid to a health care provider in excess of those allowed by the medical policies or fee guidelines." However, this provision must be read in conjunction with the immediately preceding statutory section, TEX. LABOR CODE § 413.015(b), which states "[t]he commissioner shall provide by rule for the review and audit of the payment by insurance carriers of charges for medical services provided under this subtitle to ensure compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the commissioner." Thus, while refunds are required for overpayments, they must be obtained through the Commission's audit procedures, and the Provider must be given notice of the potential overpayment and an opportunity to address it.

In this case, the potential overpayment issue has not been addressed through an audit or included in the notice of hearing. The Provider was not given an adequate opportunity to challenge it or notice that it would even be in issue in the hearing in this matter. Therefore, the ALJ finds that it is not an issue that may be considered in this proceeding. If Carrier wishes to obtain a refund, it must rely upon the Commission's procedures for audits and refunds.

In conclusion, then, the ALJ finds that Provider is entitled to reimbursement of $3,400.00 for the instrumentation procedure billed under CPT code 22842, but is not entitled to any additional reimbursement. In support of this decision, the ALJ makes the following findings of fact and conclusions of law.

I. FINDINGS OF FACT

1. ____ (Claimant) suffered an injury compensable under workers' compensation insurance.

[1] Actually, at the hearing, Carrier's attorney indicated the maximum it would owe is $1,498.50. Apparently, this number was predicated upon a reimbursement of $1,264.50 for CPT Code 22625. However, the evidence establishes that procedure was reimbursed at $1,265.00—or fifty cents more than Carrier indicated in arguments. Thus, this explains the discrepancy of fifty cents between Carrier's arguments and the ALJ's discussion in this PFD.

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

3. On or about May 9, 2003, Eric Scheffey, M.D. (Provider) obtained preauthorization from Carrier to perform a "Lumbar Laminotomy fusion Inst. L5-S1," with CPT codes 63042, 22630, and 22842, on Claimant.

4. Provider performed the preauthorized procedure on Claimant on May 20, 2003.

5. On May 23, 2003, after the surgery, Provider billed for additional codes and procedures that were not specifically listed in the preauthorization request as part of the same surgery.

6. Carrier initially denied reimbursement for all procedures but, on March 17, 2004, reimbursed Provider the sum of $5,302.00 for the procedures billed under CPT codes 22630, 22625, and 22650.

7. Carrier continued to deny reimbursement for procedures billed under CPT codes 22842, 63030, 63035, and 20975, on the basis that the procedures were not preauthorized, not medically necessary, and/or were global to other procedures.

8. After Carrier denied reimbursement for some of the services, Provider requested medical fee dispute resolution through the Texas Department of Insurance, Division of Workers' Compensation (Division).

9. On July 24, 2006, the Division issued its findings and decision, holding that Carrier was obligated to reimburse Provider the sum of $10,593.50 for the disputed services.

10. On August 30, 2006, Provider requested a hearing by the State Office of Administrative Hearings (SOAH) to challenge the Division's order.

11. Pursuant to the law at the time, Provider also filed a petition in district court for review of the Division's order.

12. Eventually, the district court dismissed the matter so it could be referred for a contested case hearing at SOAH.

13. The Division referred the matter to SOAH on November 13, 2008.

14. On November 24, 2008, the Division sent a notice of the SOAH hearing in this matter to all parties.

15. 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.

16. On March 5, 2009, 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. Provider appeared telephonically, through his authorized representative, and Carrier appeared in-person through its attorney. No other persons appeared or participated in the hearing.

17. The procedures billed under CPT codes 63030, 63035, and 20975, were distinct from the procedures that had been preauthorized, were not medically necessary treatment for Claimant's compensable injury, and required separate preauthorization.

18. The procedure billed under CPT code 22842 in the amount of $5,983.00 was properly preauthorized by Carrier and, therefore, Carrier is required to reimburse it.

19. The maximum allowable reimbursement for the procedure billed under CPT code 22842 is $3,400.00.

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. Carrier had the burden of proving by the preponderance of the evidence that it was not liable for payment of the disputed fees. 1 TEX. ADMIN. CODE § 155.427; 28 TEX. ADMIN. CODE § 148.14(a).

4. By statute, and in accordance with the applicable agency rules, spinal surgery must be preauthorized before it can be provided. TEX. LAB. CODE § 413.014(c)(1).

5. Based on the above findings of fact, Carrier has shown that it is not liable for $7,193.50 of the $10,593.50 ordered by the Division, because the specific spinal surgery procedures billed in those amounts were not preauthorized or the services were already reimbursed previously by the Carrier.

6. Based on the above findings of fact and conclusions of law, Carrier is liable to Provider for $3,400.00, and is required to pay that amount to Provider, because the procedure billed under CPT code 22842 was properly preauthorized and has not been previously reimbursed by Carrier.

ORDER

THEREFORE, IT IS ORDERED THAT Transcontinental Insurance Company is required

to pay the sum of $3,400.00 to Eric Scheffey, M.D., in reimbursement for the disputed service billed under CPT code 22842 in this case. No additional reimbursement is required.

SIGNED March 18, 2009.

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