

FINAL AWARD
(Affirming Final Award on Medical Fee Dispute)

Injury No. 12-008230
Medical Fee Dispute No. 12-01430

Employee: Trampas Crain
Employer: U.S. Engineering, Inc.
Insurer: New Hampshire Insurance Company
Health Care Provider: Elliott Curran

On June 1, 2016, the administrative law judge issued a Final Award on Medical Fee Dispute directing employer/insurer to pay \$5,600.00 to health care provider Elliott Curran. Employer/insurer filed an application for review.

We have reviewed the evidence and considered the whole record. We find that the Final Award on Medical Fee Dispute is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law, except as corrected herein. Pursuant to section 286.090 RSMo, we affirm the administrative law judge's June 1, 2016, Final Award on Medical Fee Dispute, as corrected herein.

An error appears in the final paragraph of section 1 of the administrative law judge's award. The administrative law judge wrote "The evidence is clear that the Employer/Insurer did deny authorization and merely objected to the billing codes."¹ The just-quoted sentence should read "The evidence is clear that the Employer/Insurer did **not** deny authorization and merely objected to the billing codes." We correct the award to so read.

An error appears in the second paragraph of section 2 of the award. The administrative law judge wrote "The disputed dates of service are from November 13, 2012 to January 31, 2012."² The just-quoted sentence should read "The disputed dates of service are from November 13, 2012 to January 31, 2013." We correct the award to so read.

Finally, an error appears in the final paragraph of the award. The administrative law judge wrote, "The employer/insurer are ordered to pay Mr. Elliott the sum of \$5,600.00."³ The just-quoted sentence should read "The employer/insurer are ordered to pay Mr. **Curran** the sum of \$5,600.00." We correct the award to so read.

In all other respects, we affirm and adopt the administrative law judge's findings and conclusions. We attach a copy of the administrative law judge's June 1, 2016, Final Award on Medical Fee Dispute and we incorporate its findings and conclusions, to the extent they are not inconsistent with this award.

¹ Award, p. 4.

² Award, p. 4.

³ Award, p. 5.

Employee: Trampas Crain

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Given at Jefferson City, State of Missouri, this 1st day of November 2016.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

FINAL AWARD ON MEDICAL FEE DISPUTE

Employee: Trampas Crain Injury No: 12-008230
Employer: US Engineering Inc. Medical Fee No. 12-01430
Insurer: New Hampshire Ins. Co.
Health Care Provider: Elliott Curran
Date: April 25, 2016 Checked by: LGR/pd

An evidentiary hearing was held on April 25, 2016 in Kansas City, MO on this direct payment medical fee dispute. Elliott Curran (hereinafter Health Care Provider) appeared in person and represented himself. Employer and Insurer appeared through counsel John Jurcyk.

EXHIBITS

The Health Care Provider offered the following Exhibits:

- 1 Notice of Hearing
Application for Direct Pay
Health Insurance Claim Form
Letter of Medical Necessity. Employer/Insurer made a hearsay objection. The objection is sustained and page 3 is excluded. This document was not obtained by the dispute unit per 8 CSR-50-2.030(1)(H)7.
- 2 Explanation of Bill Review

The Employer/Insurer offered Exhibits:

1. Answer to Application for Direct Pay.
2. Deposition of Kelly Redoutey.

ISSUES

1. Was the health care providers services authorized in advanced?
2. Was the device medically necessary?

FINDINGS OF FACT

Based on the evidence the facts of this case are as follows:

1. Mr. Elliott Curran testified that he is a provider of cold therapy machines used by patients following a surgery.

2. Mr. Trampas Crain received a cold therapy machine following surgery by Dr. Lowery Jones. (Ex 2, p. 18-19).
3. Mr. Curran did not speak directly to the employer or insurer regarding prior authorizations.
4. From December 14, 2012 to September 18, 2013 the Insurer paid Mr. Curran \$15,540.00 on billed charges of \$15,540.00 for the cold therapy pump. (Ex 2. P. 22). The dates of service were from April 6, 2012 until November 12, 2012. (Exhibit 2, Exhibit C)
5. Ms. Redoutey testified that the insurer would not have made payments toward the equipment unless it was authorized. (Ex 2. P. 22)
6. The services in dispute were rendered from November 13, 2012 to January 31, 2013. (Exhibit 2, Exhibit D)
7. The total charges billed for medical services provided by the Health Care provider from November 13, 2012 to January 31, 2013 totaled \$5,600.00, of which nothing was paid by the Insurer. The amount not paid by Insurer is \$5,600. (Exhibit 2 page Ex B.) According to Exhibit B. Exhibit 2, The billing was denied because "This is an unlisted procedure" or "improper coding" (Ex. 2. p. 7)
8. Employer/Insures Exhibit B of Exhibit 2 states that the billing was submitted 2/9/2015 and processed 3/6/2015. The Health Care Provider's APPLICATION FOR DIRECT PAYMENT, signed by Mr. Curran was filed with the Division of Workers' Compensation on April 4, 2015.

CONCLUSIONS OF LAW

Section 287.140 RSMo governs medical fee disputes, and provides, in relevant part:

"3. All fees and charges under this chapter shall be fair and reasonable, shall be subject to regulation by the Division or the Commission, or the Board of Rehabilitation in rehabilitation cases. A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment for services when the payor for such treatment or services is a private individual or private health insurance carrier. The Division or the Commission, or the Board of Rehabilitation in rehabilitation cases, shall also have jurisdiction to hear and determine all disputes as to such charges. A health care provider is bound by the determination upon the reasonableness of health care bills.

4. The division shall, by regulation, establish methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical

providers over fees charged, whether or not paid, and shall be in lieu of any other administrative procedure under this chapter. The employee shall not be a party to a dispute over medical charges, nor shall the employee's recovery in any way be jeopardized because of such dispute. Any application for payment of additional reimbursement, as such term is used in 8 CSR 50-2.030, as amended, shall be filed not later than: (Emphasis Added)

(1) *Two years from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered before July 1, 2013; and*

(2) *One year from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered after July 1, 2013. Notice shall be presumed to occur no later than five business days after transmission by certified United States mail.*

(6) A hospital, physician or other health care provider whose services have been authorized in advance by the employer or insurer may give notice to the division of any claim for fees or other charges for services provided for a work-related injury.... Where such notice has been filed, the administrative law judge may order direct payment from the proceeds of any settlement or award to the hospital, physician, or other health care provider for such fees as are determined by the division.

1. Was the health care providers services authorized in advanced?

According to findings in *Curry v. Ozarks Elec. Corp.* 39 S.W.3d 494 9 (Mo. Banc 2001) (overruled on other grounds by *Hampton*, 121 S.W.3d at 223, 225), “Authorize” means “to endorse, empower, justify, or permit by or as if by some recognized or proper authority (as custom, evidence, personal right, or regulating power).” WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 146 (1986).” *Curry v. Ozarks Elec. Corp.* 39 S.W.3d 494 9 (Mo. Banc 2001) at pp. 496-7.

In *Curry*, Jerry Frizzell, the president of Ozarks Electric, was aware that Mr. Curry had been injured at work and hospitalized. Mr. Frizzell acknowledged that Curry's injury was job-related and told Cox medical center billing clerk to send everything to Ozarks' workers' compensation carrier and that he needed copies of all the bills so that he would know what treatment Curry received. The employer and Insurer did not pay \$112,000 in medical bills. The court found that Mr. Frizzell by directing Cox to send Curry's medical bills to Continental Insurance and to him so that he would know what treatment Curry received is alone sufficient to establish that Ozarks “endorsed” or “permitted” the medical costs at issue. *Curry v. Ozarks Elec. Corp.* 39 S.W.3d 494 9 (Mo. Banc 2001) at pp. 496-7.

In *Miller v. Wangs*, 70 S.W.3d 671 (Mo App. S.D. 2002) (overruled on other grounds by *Hampton*, 121 S.W.3d at 223, 225), the evidence presented established that neither the employer nor the insurer provided the health care providers with authorization. The court stated: “Whether the health care services provided were “authorized in advance by the employer” involves an application of law to the facts.” *Id* at 672

The facts in *Miller* are that Ms. Miller suffered excruciating pain in her mid-back when she fell off a chair at work. She described the pain as a “sharp, stabbing pain with cramping.” The ALJ found that Claimant suffered from the kidney stone prior to the injury but the fall caused the stone to dislodge, “causing an acute obstruction and symptomatic state.” *Id* at 673. After the fall the employer directed Ms. Miller to obtain immediate medical treatment at Cox Medical Center. Claimant's employer encouraged her to receive the medical treatment by the urologist. When Claimant spoke to a representative of Insurer, she was advised that all medical bills related to the work injury would be paid. Cox Medical Center and Dr. Milne provided the medical care without obtaining in advance authorization from the employer and insurer. *Id* at 672.

The Court in *Miller* stated that: The statute does not require that the authorization be given to the health care provider. It allows for direct payment when the provider's “**services have been authorized in advance by the employer or insurer.**” Nowhere does it provide that the authorization must be given in advance to the health care provider. *Id* at 675 (emphasis added)

The Application for Direct Payment was filed within the time allowed by law. The facts before this agency are undisputed that the Mr. Curran did not seek direct authorization from the employer/insurer regarding the medical device. It is further undisputed that the Insurer paid Mr. Curran for dates of service from April 6, 2012 until November 12, 2012. (Exhibit 2, Exhibit C). Ms. Redoutey testified that the insurer would not have made payments toward the equipment unless it was authorized. (Ex 2. P. 22).

The dates of services in dispute are from November 13, 2012 to January 31, 2013 in the amount of \$5,600.00. (Exhibit 2, Exhibit B) This bill was denied by the insurer because “This is an unlisted procedure” or “improper coding” (Ex. 2. p. 7). There is no factual dispute in the evidence that the insurer authorized the cold therapy machine just one day in advance of the disputed dates of service. The evidence is clear that the Employer/Insurer did deny authorization and merely objected to the billing codes. According to *Miller v. Wang* the law does not require Mr. Curran to have personally received direct prior authorization from the Employer/Insurer. *Supra* Based upon the evidence, the cold therapy machine was authorized by the Employer/Insurer.

2. Was the device medically necessary?

The uncontested evidence in this case is from December 14, 2012 to September 18, 2013 the Insurer paid Mr. Curran \$15,540.00 on billed charges of \$15,540.00. The paid dates of service were from April 6, 2012 until November 12, 2013. (Exhibit 2, Exhibit C) Accordingly, the Employer/Insurer concede the device was authorized and therefore medically necessary during this period of time.

The disputed dates of service are from November 13, 2012 to January 31, 2012 and totaled \$5,600.00. According to Exhibit B. Exhibit 2, the billing was denied because “This is an unlisted procedure” or “improper coding” (Ex. 2. p. 7). Based upon the previous payments made by the insurer and the duration of prior services being authorized just one day before the dates of

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Employee: Trampas Crain

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the contested billing codes, the evidence demonstrates that the device was medically necessary. In addition, the evidence demonstrates the charges of \$5,600.00 are fair and reasonable. The employer/insurer are ordered to pay Mr. Elliott the sum of \$5,600.00.

Made by: _____
Lawrence G. Rebman
Administrative Law Judge
Division of Workers' Compensation