IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Mark T. Allen, M. D.,	:	
Petitioner	:	
	:	
v.	:	
	:	
Bureau of Workers' Compensation	:	
Fee Review Hearing Office	:	
(Kemper Insurance),	:	No. 2219 C.D. 2003
Respondent	:	

O R D E R

AND NOW, this 22nd day of June, 2004, it is ORDERED that the above-captioned opinion filed March 26, 2004 shall be designated OPINION rather than MEMORANDUM OPINION, and it shall be reported.

BERNARD L. McGINLEY, Judge

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Mark T. Allen, M. D.,	:	
Petitioner	:	
	:	
v.	:	
	:	
Bureau of Workers' Compensation	:	
Fee Review Hearing Office	:	
(Kemper Insurance),	:	No. 2219 C.D. 2003
Respondent	:	Submitted: February 6, 2004

BEFORE: HONORABLE BERNARD L. McGINLEY, Judge
HONORABLE MARY HANNAH LEAVITT, Judge
HONORABLE CHARLES P. MIRARCHI, JR., Senior Judge

OPINION BY
JUDGE McGINLEY FILED: March 26, 2004

Mark T. Allen, M.D. (Dr. Allen) petitions for review from the order of the Department of Labor and Industry, Bureau of Workers' Compensation, Fee Review Hearing Office (Office) which denied the payment of bills Dr. Allen submitted for fee review.

Dr. Allen through his billing agent, Craig Rosen (Rosen), billed Kemper Insurance (Kemper) for vertebral axial decompression treatments (VAX-D)[1] treatments for Oliver Nestor on March 2, 7-9, 12, and 15-16, 2001. Rosen

[1] VAX-D treatment is a non-surgical spinal decompression treatment for patients with low back pain and involves the use of a split table which consists of both fixed and moveable sections. A pelvic harness with a distraction force is attached to the patient and his spine is gradually stretched to relieve pressure on compressed discs.

assigned Code 97799, a miscellaneous billing code, for the VAX-D treatments because Medicare lacks a specific code for the treatment.[2]

By letter dated April 16, 2001, (Letter), Christine Clark (Clark) of Kemper informed Dr. Allen that Kemper would no longer pay for VAX-D treatments under Code 97799 but under Code 97012.[3] The payment level for Code 97012 is less than Code 97799. The letter also informed Dr. Allen that he had ten days to respond to the changes. Kemper did not receive a response from either Dr. Allen or Rosen. On June 11, 2001, Kemper issued a check for the VAX-D services under Code 97012.

Dr. Allen applied for a fee review with the Bureau of Workers' Compensation (Bureau) and requested review of the amount of payment by Kemper for the VAX-D treatments from March 2 through March 16, 2001. On July 20, 2001, the Bureau issued an administrative decision in favor of Kemper. Dr. Allen appealed to the Office and requested a *de novo* hearing.

On October 23, 2002, the Office conducted a hearing. Kemper's counsel, Doreen L. Prescott (Prescott), argued that Dr. Allen had ten days to

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[2] The parties stipulated that the Medicare coding scheme is the coding scheme used in Workers' Compensation.

[3] The Letter stated that Code 97012 was "defined as a modality, being any physical agent applied to produce changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical or electric energy, not requiring direct (one to one) contact by the provider specifically, traction, mechanical." Letter from Christine Clark, April 16, 2001, at 1-2; Reproduced Record (R.R.) at 253-254.

respond under the applicable regulation, 34 Pa.Code §127.207[4], failed to do so, and, consequently, Dr. Allen could not at the hearing argue about the downcoding of VAX-D treatments.

Rosen testified that when he received the Letter he made two attempts to reach Clark by telephone, though he did not keep a log of the calls. Notes of Testimony, October 23, 2002, (N.T.) at 74, 77; R.R. at 90, 94. Rosen admitted that after he received the check based on Code 97012 he filed a fee review challenging the amount of payment "even though I know the ten-day rule had elapsed." N.T. at 76; R.R. at 93. On cross-examination, Rosen admitted that he did not respond in ten days as requested in the letter and did not respond at all in writing.[5] Rosen

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[4] The applicable Bureau regulation concerning downcoding by insurers, 34 Pa.Code §127.207, provides:

> (a) Changes to a provider's code by an insurer may be made if the following conditions are met:
> (1) The provider has been notified in writing of the proposed changes and the reasons in support of the changes.
> (2) The provider has been given an opportunity to discuss the proposed changes and support the original coding decisions.
> (3) The insurer has sufficient information to make the changes.
> (4) The changes are consistent with Medicare guidelines, the act and this subchapter.
>
> (b) For purposes of subsection (a)(1), the provider shall be given 10 days to respond to the notice of the proposed changes, and the insurer must have written evidence of the date notice was sent to the provider.

[5] Kemper's counsel, Doreen L. Prescott, questioned Rosen about his response to the April 16, 2001, letter:

> Q: Mr. Rosen, you testified that you did receive the April 16th letter from Christine Clark. In that letter it states that you have ten days to respond to these changes. Did you respond in ten days, as requested by the letter? Did you at all respond in writing?

(Footnote continued on next page…)

explained that he did not submit anything in writing because Kemper was not going to change and VAX-D could not be confused as a traction device. N.T. at 86-87; R.R. at 104-105.[6]

On September 9, 2003, the Office denied any further payment of bills submitted under the fee review:

> In response to Provider's [Dr. Allen] billing, reporting and coding/treatment information, Insurer [Kemper] issued written notification to Provider [Dr. Allen], dated April 16, 2001, advising therein that Insurer [Kemper] proposed to change Provider's [Dr. Allen] billed miscellaneous code for the VAX-D treatment, 97799, to a more specific, 'comparable' code, that is, 97012, identified for use in reporting a modality, i.e. mechanical traction. . . . Insurer [Kemper] detailed its' [sic] reasons in support of the proposed change to code 97012 . . . and specifically advised Provider [Dr. Allen] therein that, according to Pennsylvania regulatory authority, Provider [Dr. Allen] had ten days to respond to this proposed code change notice. Provider's billing agent [Rosen] acknowledged receiving Insurer's [Kemper] April 16, 2001 letter notification in and about that time, and further, conceded that he did not respond to this written notification of code change within ten days. Insurer [Kemper], in the absence of any Provider [Dr. Allen] response in support of its' [sic] coding, subsequently issued payment to Provider [Dr. Allen] based upon the reimbursement rate applicable for the changed code that is 97012. Accordingly, in light of these established facts

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(continued…)

A: No.

N.T. at 84-85; R.R. at 102-103.

[6] Raymond E. Silk, M.D., board-certified in general surgery, quality assurance, utilization review, and risk management, described the VAX-D treatment and the benefits associated with it.

> and upon consideration of the aforestated, plainly worded statutory and regulatory code change authority, the question of Insurer's [Kemper] compliance with the relevant code change authority must be answered affirmatively. Further, insofar as Provider [Dr. Allen] failed to offer any support for its' [sic] original coding decision within the requisite time period, consideration of Provider's [Dr. Allen] assertions that Insurer [Kemper] incorrectly coded the non-surgical decompression treatment and/or evidence present in support of same is unnecessary.

Hearing Officer's Decision, September 9, 2003, at 6-7; R.R. at 13-14.

Dr. Allen contends that the Hearing Officer wrongfully determined that Kemper permissibly changed the VAX-D treatments to Code 97012 and wrongfully determined that Dr. Allen was not due additional payments as a result.[7] Dr. Allen asserts that the Hearing Officer impermissibly imposed a requirement that he respond to Kemper's change of the code of the VAX-D treatment within ten days.

Section 306(f.1)(3)(viii) of the Workers' Compensation Act (Act)[8] provides in pertinent part: "Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has sufficient information to make the changes and following consultation with the provider." The applicable Bureau regulation concerning downcoding by insurers provides that the provider has ten days to respond to the notice of proposed changes.

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[7] Our review is limited to determining whether constitutional rights were violated, whether an error of law was committed or whether the necessary findings of fact were supported by substantial evidence. Royal Insurance v. Department of Labor and Industry, Bureau of Workers' Compensation (Spine Center), 728 A.2d 401 (Pa. Cmwlth. 1999).

[8] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §531(3)(viii).

It is clear from the record that Kemper complied with the Act and the regulation when it downcoded the VAX-D treatment. Under the regulation Dr. Allen had ten days to respond. He failed to do so. The Office did not err when it determined that Dr. Allen was not permitted to raise his objections to the downcoding at the hearing when he did not comply with the ten day requirement.

Accordingly, we affirm.

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BERNARD L. McGINLEY, Judge

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Mark T. Allen, M. D., Petitioner	:	
v.	:	
Bureau of Workers' Compensation Fee Review Hearing Office (Kemper Insurance), Respondent	:	No. 2219 C.D. 2003

O R D E R

AND NOW, this 26th day of March, 2004, the order of the Bureau of Workers' Compensation, Fee Review Hearing Office in the above-captioned matter is affirmed.

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BERNARD L. McGINLEY, Judge