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DEPARTMENT OF  
HEALTH AND HUMAN SERVICES  
Social Security Administration  
OFFICE OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF

[REDACTED]

(Appellant)

[REDACTED]

(Beneficiary)

BLUE CROSS/BLUE SHIELD

(Carrier/Intermediary/PRO)

CLAIM FOR

Supplementary Medical  
Insurance Benefits

[REDACTED]

(HICN)

000-42-2148

(Docket Number)

This case is before the Administrative Law Judge upon remand by the Appeals Council. By order dated April 20, 1994, the Appeals Council vacated the Administrative Law Judge's decision dated October 4, 1993, and remanded the case to the undersigned Administrative Law Judge for further proceedings.

A supplemental hearing was held on March 14, 1995. Judy Wright, of Blue Cross/Blue Shield of Arkansas, testified under subpoena at a hearing held on March 14, 1995, in Knoxville, Tennessee. The appellant(s) was (were) represented by Lenny Croce. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

The Appeals Council remanded the case for further consideration of the allowance for procedure codes 21145 and 21143 and for additional rationale for declining to apply medicare policy regarding reduction of fee for second procedure performed on the same patient by the same physician on the same day.

The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits the testimony at the hearing, and the arguments presented.

Additional evidence of record includes a statement obtained from an oral surgeon who has performed a number of the procedures at issue in the Knoxville area. Dr. Moye, a Diplomate of the American Board of Oral and Maxillofacial surgery, states that the fee range in the local area for the LeForte I procedure is between \$2549 and \$3340. If the maxilla is segmented, the fees range from \$3733 to \$4892. The surgical fee for TMJ (CPT 21243) total joint arthroplasty and total joint replacement ranges from \$3463 to \$4538. A segmented LeForte plus total joint replacement would range from \$7196 to \$9430.

In a subsequent report of contact, Dr. Moye indicated that the procedure was performed by only a few physicians in the country, due to its complexity. Due to the inherent complexity of the procedure, the fees for the procedure could vary significantly.

Subsequent to the hearing, Dr. Lewis, who performed the procedures, submitted a statement into evidence reflecting that he had performed 30 LeForte I procedures in 1990 and 1991. The procedure code was #21145. The standard fee was \$3750. The total joint reconstruction fee (procedure 21243) was \$3000, broken down into components. He performed 9 such surgeries throughout 1991 and 1992, all for the same fee. The septoplasty (#30520) fee was \$1200, using Blue Cross UCR fee of \$1300 as a guideline. Dr. Lewis added that he could not see the relevance of Medicare's considering the procedure to be overpriced or overvalued service, when Mrs. Croce's septal reconstruction was a complex procedure due to the crushing of her septum from her injury.

Dr. Lewis added that Mrs. Croce's case was far more complex than average; nonetheless, no additional fees were charged above the normal fee.

Mr. Croce contends that the carrier produced no data to support the allowed charge for procedure 30520 and made no proof concerning why the procedure was overvalued or overused or why that would be relevant to these circumstances. He contends that the calculation of the rate was not in accordance with the

Regulations, but was "simply picked out of the air". Under Regulation, the carrier is to pay the reasonable charges for similar services generally made by the treating oral surgeon or by other persons furnishing such services. 42 CFR 405.502 (a). The carrier instead based its fee determination on its oral surgeon consultant, without providing information as his qualifications to make such a determination.

A representative from the carrier, Blue Cross-Blue Shield of Arkansas, was subpoenaed to give testimony as to how the carrier had established the allowable charges for the procedures. The representative gave her qualifications as being those of a Registered Nurse. She stated that there was no relevant statistical data base upon which charge guidelines could have been developed. She therefore consulted the medical director, who established the allowances at issue. She stated that she was not familiar with his qualifications for doing so, and did not know whether he was familiar with the procedures or had ever performed the procedures himself. She stated that if there is insufficient data, the carrier has discretion to fill in the gaps and derive a reasonable charge, which occurred in this case. She also testified that the method of reimbursement changed in 1991 to reimbursement based on Relative Value Units.

The carrier has submitted a computer run of fees for procedures for which the allowance is \$2500 and justifies the allowance for procedure codes 21145 and 21243 on the basis of relative value unit derived fees for 1996.

In determining the reasonable charge for the procedures, 4 primary sources of charge information are considered: (1) The provider's median charge for the service during the July 1 through June 30 preceding fiscal year period; (2) the prevailing charge by other physicians of the same specialty for the same service (3) the fiscal Year 1972 prevailing charge for the service increased by the Medicare Economic Index and (4) the physician's charge on the claim at hand.

"Reasonable" is strictly defined by the law and regulations and is the lowest of the four criteria.

The Administrative Law Judge may review the correctness of the billing codes where an allegation has been made that a particular

code is inappropriate or incorrect and the Administrative Law Judge may review the statistical data used by the carrier to fix a reasonable charge where an allegation is made that the carrier had used a data base that is invalid or incorrect.

42 CFR 405.506 provides that a charge which exceeds either the customary charge of the physician or other person who rendered the service, or the prevailing charge in the locality, or an applicable lowest charge level may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort, or expense which support an additional charge, and only if it is acceptable medical service practice in the locality to make an extra charge in such cases.

There is no question that there was no determination of the customary or the prevailing charge either by the carrier or by the fair hearing officer with regard to the charges in dispute.

From information present in the record, there is a data base of 30 LeForte 1 procedures performed during 1990 and 1990 by the provider, for which the fee was \$3750. He performed the TMJ total joint reconstruction with prosthesis on 9 occasions in 1992 and 1992 and the fee has been \$3000. (#21243). The provider states that the Blue Cross established usual and customary fee for a septoplasty is \$1300; he billed \$1200 for the procedure, which was a complex procedure to reconstruct her nose and nasal function following a crushing injury.

Dr. Lewis's charges are in line with the range of charges for the procedure as reported by Dr. Moye above. (\$7196 to 9430).

The undersigned finds that there is no basis in empirical fact, whether in examining comparable charges, prevailing charges, or other statistical data to have found that \$2500 was a reasonable charge for procedure code 21243, or that \$2500 was a reasonable charge for procedure code 21245, or that the allowance for procedure code 30520 should have been reduced by 50 per cent of the prevailing fee. The \$2500 fees were based solely upon the opinion of the carrier's medical consultant, which, while apparently complying with the carrier's internal policy, was not based upon a valid data base. In light of the invalidity of the data base used to approximate a prevailing charge, it the

Administrative Law Judge's opinion that Dr. Lewis' customary charges of \$3750 and \$3000, his charges in the case at hand, is reasonable in connection with this matter, particularly in light of the unusual circumstances involving additional time, effort, and expense, as well presented in the record. The reasonableness of the charges for the procedures is further supported by the evidence from the medical expert showing prevailing charges comparable to or greater than the charges in this case.

With regard to the reduction in the fee allowance for the septoplasty, the provider's representative testified that she knew of no common incision or other fact that would justify a reduction in fee for the procedure: she knew that it was usually performed to improve breathing, but she did not know if anyone from her office had talked to Dr. Lewis to find out why he did this particular surgery for the patient in this case. She could not explain why the fee was reduced.

The undersigned does not find a basis in the facts or in the law and Regulations for reducing the fee for the septoplasty, based on the consideration that the Social Security Act is "a remedial statute that should be construed liberally 'in favor of coverage, if such a construction is reasonable'". Tingus v. Heckler, 569 F.Supp. 1499, 1501 (D.Mass. 1983), and based further on a consideration of the complexity of the case and the consideration that the surgery was performed as part of the post-traumatic reconstruction of the face, and based on the total dearth of evidence that this surgery could possibly be construed an overused or overvalued procedure to which the policy might be applicable.

It is noted that the provider in this case did not take assignment.

#### FINDINGS

After careful consideration of the entire record, the undersigned Administrative Law Judge makes the following findings:

1. The amounts in controversy are \$3750, \$3000, and \$1200.

2. The following medical services covered under the Medicare Part B program were provided by Dr. Robert Lewis, DDS, to Faith Croce on July 10, 1991: LeForte I Single Procedure; TMJ Total Joint Prosthesis: Septoplasty.
3. The corresponding procedure codes for these services are 21145; 21243 (221243 + 21060+ 21050); 30520.
4. Due to lack of a reliable data base, the allowance for procedure code 21145 and 21243 is not established based upon "the prevailing charge" (§ 1842(b) of the Act; 42 CFR § 405.502(a)).
5. Unusual circumstances or medical complications arose during the course of treatment which required additional time, effort or expense (42 CFR § 405.506).
6. It is acceptable medical or medical service practice in the locality to make an additional charge when unusual circumstances or medical complications arise which require additional time, effort or expense (42 CFR § 405.506)
7. The actual charge and the physician's customary charge for the procedures coincide and are \$3750 and \$3000 respectively, charges which are supported by all available data on prevailing charge. § 405.506); the reasonable charge for the procedures is accordingly \$3750 and \$3000, respectively.
8. The allowance for services rendered by Dr. Lewis, procedure code, #30520, should not be reduced 50% pursuant to carrier's multiple surgery policy; the reasonable charge for the procedure is \$1200, the physician's actual charge.

DECISION

It is the decision of the undersigned that the total allowance for these claims is \$7950. Therefore, the carrier is directed to make an additional payment based upon an increase in the allowance established under Part B of Title XVIII.



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JOHN D. HENSON  
Administrative Law Judge

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APR 18 1966  
Date