IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Freedom Medical Supply Co., Inc., Petitioner	:	
v.	:	No. 544 C.D. 2013
	:	Submitted: October 4, 2013
Bureau of Workers' Compensation Fee Review Hearing Office (Chartis Casualty Co.), Respondent	:	

BEFORE: HONORABLE DAN PELLEGRINI, President Judge
HONORABLE RENÉE COHN JUBELIRER, Judge
HONORABLE ROCHELLE S. FRIEDMAN, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
PRESIDENT JUDGE PELLEGRINI FILED: October 25, 2013

Freedom Medical Supply Company, Inc. (Provider) petitions for review of the decision of the Fee Review Hearing Officer of the Bureau of Workers' Compensation Fee Review Hearing Office (Bureau) denying and dismissing Provider's appeal of a determination by the Health Care Services Review Division that it was not owed $1,600.00 by Chartis Casualty Company (Insurer) for services it provided to Michael Williams (Claimant) pursuant to the Pennsylvania Workers' Compensation Act (Act).[1] We reverse.

[1] Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §§1 – 1041.4, 2501 – 2708.

Provider filed an application for fee review pursuant to Section 306(f.1)(5) of the Act[2] seeking, *inter alia*, $1,600.00 in payment for a neuromuscular stimulator (HCPC Code E0745) that it provided to Claimant on April 3, 2012. Insurer had denied payment for the neuromuscular stimulator on the basis that no modifier was billed with that item so that appropriate reimbursement could not be determined. (Reproduced Record (R.R.) at 10a-11a).[3] The Bureau denied Provider's claim with respect to the neuromuscular stimulator on a different basis – that Provider did not submit a prescription or certificate of medical necessity for that service.

[2] 77 P.S. §531(5). Section 306(f.1)(5) provides, in pertinent part:

> (5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment…. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

[3] The 2013 Workers' Compensation Part B Fee Schedule indicates that there is no modifier necessary for E0745 service. (R.R. at 20a).

Provider filed a request for a hearing to contest the fee review determination[4] before the Fee Review Hearing Officer at which Insurer did not appear.[5] Provider rested on all of the certified documents that were submitted to the Bureau in support of the application and the hearing was closed. On March 5, 2013, the Hearing Officer issued a decision denying and dismissing Provider's request for payment because it did not provide a prescription for the neuromuscular stimulator while finding that the certified record included "[a] February 24, 2012 prescription by Dr. Brent Weinerman for a 'Portable Home Whirlpool' and a 'Portable Muscle Stimulator and Supplies.'" (Hearing Officer Decision at 2). Provider then filed the instant appeal.[6]

Provider argues, *inter alia*, that the Hearing Officer erred in affirming the denial of payment for the neuromuscular stimulator on the basis that Provider did not submit a prescription or certificate of medical necessity for that service where the certified record contains a prescription for that service.[7] We agree.

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[4] Initially, the Hearing Officer dismissed Provider's request for a hearing as untimely, but vacated that decision and order on February 23, 2013.

[5] Insurer also failed to appear at a prior hearing on October 10, 2012.

[6] This Court's scope of review of a fee review decision of a Bureau hearing officer is limited to considering whether necessary factual findings are supported by substantial evidence, whether any constitutional rights were violated, and whether the hearing officer erred as a matter of law. Section 704 of the Administrative Agency Law, 2 Pa. C.S. §704; *Legion Insurance Company v. Bureau of Workers' Compensation Fee Review Hearing Office (Ferrara)*, 42 A.3d 1151, 1153 n.6 (Pa. Cmwlth. 2012).

[7] By order dated August 19, 2013, Insurer was precluded from arguing or filing a brief because it failed to file a brief by the date it was due.

Section 306(f.1)(1)(ii) of the Act provides that "[t]he employer shall provide payment for medicines and supplies … in accordance with this section…." 77 P.S. §531(1)(ii). In addition, as noted above, Section 306(f.1)(5) states that the "employer or insurer shall make payment … in accordance with the provisions of this section" and that "[a]ll payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)…." 77 P.S. §531(5). Because Insurer did not dispute the reasonableness or necessity of the neuromuscular stimulator, payment was due for this service within 30 days of receipt of Provider's bill. *Id.* Moreover, 34 Pa. Code §127.259(a) provides that, at the hearing on Provider's application, the Hearing Officer was required to conduct a *de novo* proceeding and, under 34 Pa. Code §127.259(f), the burden was on Insurer "of proving by a preponderance of the evidence that it properly reimbursed the provider."

However, Insurer's basis for denial, that a modifier is necessary for the neuromuscular stimulator, is belied by the 2013 Workers' Compensation Part B Fee Schedule which indicates that there is no modifier necessary for E0745 service. (R.R. at 20a). In addition, the Bureau's basis for denial that Provider did not submit a prescription or certificate of medical necessity for that service is belied by the certified record and the Hearing Officer's findings of fact because Provider did submit a February 24, 2012 prescription by Dr. Weinerman for a "Portable Muscle Stimulator and Supplies." (*Id.* at 7a). Nevertheless, the Hearing Officer failed to consider either of the foregoing in disposing of Provider's timely application for payment.

Accordingly, the Hearing Officer's decision is reversed and Insurer is directed to pay Provider $1,600.00 as billed under the Act.

DAN PELLEGRINI, President Judge

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O R D E R

AND NOW, this 25th day of October, 2013, the decision of the Fee Review Hearing Officer of the Bureau of Workers' Compensation Fee Review Hearing Office dated March 5, 2013, at No. 333967, is reversed and Chartis Casualty Co. is ordered to pay Freedom Medical Supply Co., Inc. $1,600.00 as billed under the Pennsylvania Workers' Compensation Act.

DAN PELLEGRINI, President Judge