BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

OHS COMPCARE	)	Docket No. 8500000
Appellant	)	Claimant: Danette K. Michaels
	)	Docket No. 8500001
AND	)	Claimant: Scott Parsley
	)	Docket No. 8500002
KASB RISK MANAGEMENT SERVICES;	)	Claimant: Amy Smith
KANSAS MUNICIPAL INSURANCE	)	Docket No. 8500003
TRUST; ALTERNATIVE RISK	)	Claimant: Oliver Ison
SERVICES, et al.	)	Docket No. 8500004
Appellees	)	Claimant: Terry W. Horner
	)	Docket No. 8500005
	)	Claimant: Stacy J. Kahnt
	)	Docket No. 8500006
	)	Claimant: Teresa Truman

ORDER

OHS Compcare (OHS) appealed the November 14, 2008, Initial Order entered by Department of Administration Hearing Officer Sandra L. Sharon. In its Order of May 26, 2009, the Workers Compensation Board dismissed the appeal on the basis the issues were not ripe for review as the parties had not obtained an appealable order from the Director of Workers Compensation (Director).

The Board's Order was appealed to the Kansas Court of Appeals by the Director. On May 21, 2010, the Kansas Court of Appeals ruled the Board had the jurisdiction and authority to review the Initial Order entered by the hearing officer. Accordingly, the Kansas Court of Appeals remanded this proceeding to the Board to review the Initial Order on its merits.[1]

The Board heard oral argument on August 20, 2010, in Topeka, Kansas. Stacy Parkinson was appointed by Director Greathouse to serve as a Board Member Pro Tem in place of Board Member Carol Foreman, who recused herself from this matter.[2]

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[1] *Greathouse v. KASB Risk Management Services; Kansas Municipal Insurance Trust; Alternative Risk Services, et al.*, No. 102,640, unpublished Court of Appeals Memorandum Opinion filed May 21, 2010.

[2] Carol Foreman subsequently retired from the Board.

APPEARANCES

George Verscheldon of Kansas City, Missouri, appeared for OHS. Frederick J. Greenbaum of Kansas City, Kansas, appeared for Kansas Municipal Insurance Trust, Alternative Risk Services, and KASB Risk Management Services (the insurers). There were no other appearances.

RECORD AND STIPULATIONS

By written stipulation filed May 15, 2009**,** the parties agreed to the record to be considered by the Board on this appeal. The parties also presented to the hearing officer a written stipulation agreeing to the facts set forth in Appendix I.[3]

ISSUES

This is a proceeding initiated under K.S.A. 44-510j over disputed medical fees claimed by OHS for services provided under the Workers Compensation Act (Act) to seven injured workers. The insurers disputed they owed the amounts charged by OHS for the 10 office visits in question. The dispute ultimately went to formal hearing and the hearing officer ruled the charges in question submitted by OHS were inflated and that the reduced billing codes and resulting charges determined by Shorman Solutions (Shorman), a company hired by the insurers to audit the billings, were appropriate.[4]

The Act provides that the fees charged for medical treatment rendered under the Act are to comply with the medical fee schedule developed by the Division of Workers Compensation (Division).[5] OHS argues the Division's medical fee schedule allows providers to use the 1995 Centers for Medicare and Medicaid Service (CMS) *Documentation Guidelines for Evaluation and Management Services* (1995 CMS guidelines*)* in determining the appropriate current procedural terminology (CPT) medical codes for its billings; that its certified medical code specialists used and complied with those 1995 CMS guidelines for the 10 billings in question; OHS has properly coded its services under the Division's medical fee schedule; and, therefore, it is entitled to payment in full for the charges submitted.

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[3] Joint Stipulation of Facts and Exhibits. This document is not dated nor is the date of receipt noted on the document.

[4] But see *Roles v. Boeing Co.*, 43 Kan. App. 2d 619, 627, 230 P.3d 771 (2010), holding that the utilization review procedures in K.S.A. 44-510j are not available.

[5] K.S.A. 444-510j(h).

OHS maintains that Shorman did not use certified medical code specialists to audit and evaluate the CPT codes and billings in issue and that Shorman ultimately utilized the 1997 CMS *Documentation Guidelines for Evaluation and Management Services* (1997 CMS guidelines*)*, if any, which OHS contends are intended for specialists and not readily used by the medical community or the insurance carriers in this state. Also, OHS contends the 1995 CMS guidelines are the industry standard as they are regularly used by the medical coding profession and by the majority of medical providers and health insurance carriers in this state, and those guidelines are recommended by OHS's medical malpractice insurer.

Furthermore, OHS argues the report prepared by the Kansas Foundation for Medical Care (KFMC) should be ignored as the report allegedly did not conclude that the CPT codes utilized by OHS for the 10 billings in question were excessive. OHS also believes the KFMC report should be disregarded as KFMC did not use a certified medical coder in its evaluation process and did not follow either the 1995 or 1997 CMS guidelines. In short, OHS contends the KFMC report is based upon subjective standards as its conclusions are based upon a doctor's belief of custom and practice rather than based upon objective standards.

Finally, OHS argues the burden of proof lies with the insurers and they have failed to prove that OHS's billings were excessive. OHS maintains that no one testified that its billings were excessive and, furthermore, the hearing officer merely concluded its billings were inflated rather than excessive. OHS asserts that, at most, the evidence shows reasonable people may disagree on medical codes and billings.

In short, OHS asks the Board to reverse the November 14, 2008, Initial Order and find that OHS's medical billing codes and fees are consistent with Kansas law and are not excessive.

The insurers contend the Board should affirm the hearing officer's Initial Order. They argue the correct standard for determining medical codes is the *Current Procedural Terminology CPT 2007* publication (*CPT 2007).* They maintain the 10 billings in question were excessive as they were based on incorrect medical codes as established by the testimonies of Shorman's employees, Donna McNeill and Michelle Myers, both of whom are registered nurses; the KFMC reports; and the testimony of Dr. Jeffrey Wheeler, who is the medical director of KFMC, a non-profit foundation that primarily provides peer review services for the federal government's Center for Medicare and Medicaid Services (CMS). The insurers also argue that Shorman's expertise in CPT billing codes is evidenced by KFMC agreeing with Shorman's codes in all but one instance.

The insurers frame the issue on this appeal as being whether OHS's medical records contain sufficient information and documentation to support its billing codes. They argue the physician's notes must set out the services provided in sufficient detail to substantiate the code utilized. For example, they assert a coder may not accept without supporting documentation and findings that a doctor provided a certain level of examination or provided specific services.[6]

In any event, the insurers maintain there is substantial, competent evidence in the record to support the hearing officer's findings and conclusion that OHS submitted inflated billings for the 10 visits in question. The hearing officer found, in pertinent part:

> 8. Ms. Ordal's explanation of her audit included reading the physician's note and identifying separate sub-components of each area of the office visit to determine at what level the history, exam, and decision making should be billed. Ms. Ordal indicated that it is not the coder's job to second guess what the physician puts in his documentation and that mention in an examination of a sub-component warrants credit that the sub-component was appropriate to include in the code billed. The inclusion of the sub-components is plotted out and the equation results in the billing level which should represent the level of degree of the office visit.
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> 9. The flaw in this position is not that the coder cannot identify what the physician's examination entailed, but the flaw is in the translation of the code words related to the sub-components only identify they were addressed. They do not quantify the actual care or attention provided in the examination. This is an integral part of the coding/billing systems. The purpose is to be able to quantify the actions of the physician and effectively communicate it to a third party payor. A coder's recognition of a physician's mention of a system or sub-component does not quantify services provided.
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> . . . .
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> 11. The mere mention of a body system or area does not communicate the degree to which care and attention was provided. Therefore, making a tally of the systems mentioned without a more definitive or quantative [*sic*] statement from the physician results in inflated coding submitted to the third party payor.
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[6] OHS contends that it is sufficient for its physicians to utilize the *CPT 2007* terminology rather than listing each component of the examination or evaluation.

> 13. As to the Evaluation and Management codes, the Presiding Officer finds that a quantative [*sic*] aspect of evaluation process is lacking and as a result inflated claims were submitted for payment by the Respondent on all medical claims which are the subject of review in this matter.[7]

The sole issue before the Board on this appeal is whether there is substantial, competent evidence in the record to support the hearing officer's findings and conclusion that OHS's billings were inflated and that the modifications made by the insurers to those billings were appropriate.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the entire record, the Board finds and concludes the Initial Order should be affirmed as there is substantial, competent evidence in the record to support the hearing officer's findings that OHS's charges were inflated and that Shorman's modifications to OHS's medical codes were appropriate.

As indicated above, this dispute involves the medical codes and charges regarding 10 office visits from 7 different injured workers. In each instance, Shorman, who was hired by the insurers to review and audit the medical charges in question, determined the medical records did not justify the codes utilized by OHS for its billings. Also in each instance, Shorman determined the medical codes should be modified to reflect a lower level of service, which reduced the amounts owed OHS.

The dispute went through both the informal and formal hearing procedures for disputed medical charges as set forth by the Workers Compensation Act in K.S.A. 44-510j, and the insurers prevailed before the hearing officer.

Disputes over medical charges and the burden of proof.

The Act provides that all health care providers providing services under the Act are bound by the medical fee schedule approved by the Director of the Division of Workers Compensation. K.S.A. 44-510j(h) provides in part:

> Any health care provider, nurse, physical therapist, any entity providing medical, physical, or vocational rehabilitation services or providing reeducation or training pursuant to K.S.A. 44-510g and amendments thereto, medical supply establishment, surgical supply establishment, ambulance service or hospital which accept the terms of the workers compensation act by providing services or material thereunder shall be bound by the fees approved by the director and no injured

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[7] Initial Order (Nov. 14, 2008) at 4-5.

> employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director.

When there is a dispute among the parties over a medical bill, the Act provides an informal hearing. And if the informal hearing does not settle the dispute, the Act provides for a formal hearing. K.S.A. 44-510j provides, in part:

> (d) After the entry of the order indicating that the parties have not settled the dispute after the informal hearing, the director shall schedule a formal hearing.
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> . . . .
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> (2) The formal hearing shall be conducted by hearing officers, the medical administrator or both as appointed by the director. During the formal hearing parties to the dispute shall have the right to appear or be represented and may produce witnesses, including expert witnesses, and such other relevant evidence as may be otherwise allowed under the workers compensation act. If the director finds that a provider or facility has made **excessive** charges or provided or ordered unjustified treatment, services, hospitalization or visits, the provider or facility may, subject to the director's order, receive payment pursuant to this section from the carrier, employer or employee for the excessive fees or unjustified treatment, services, hospitalization or visits and such provider may be ordered to repay any fees or charges collected therefor. . . . (Emphasis added.)

In this proceeding the insurers only contest the amount of the charges. They do not contend OHS provided or ordered unjustified treatment or services.

The Act is silent as to which party has the burden of proof in these proceedings. Must OHS, in order to prevail, prove that its billings are not excessive as they are within the medical fee schedule? Or must the insurers prove OHS's charges exceed the fees allowed by the Division's medical fee schedule? Or is there a different burden? The insurers suggest the burden of proof is neutral.

The Board finds the medical provider must first establish a *prima facie* case that its charges are allowed by the Division's medical fee schedule. At that point the burden of going forward with the evidence shifts to the insurer or payer to establish that a particular billing is excessive.

The medical fee schedule and CPT codes.

K.S.A. 2009 Supp. 44-510i requires the Director to develop and maintain a medical fee schedule to help control the medical costs for treating injured workers under the Workers Compensation Act. The medical fee schedule adopted by the Director requires

medical providers to utilize the five-digit CPT medical codes in their billings. The *Workers Compensation Schedule of Medical Fees* that was implemented on December 1, 2005, remained in effect until January 1, 2008. That medical fee schedule incorporates by reference the *Current Procedural Terminology, Fourth Edition,* of the American Medical Association.[8]

The parties entered into the record a copy of the *CPT 2007 Professional Edition*,[9] which explains in its introduction how using its medical codes simplifies the reporting process:

> *Current Procedural Terminology (CPT), Fourth Edition*, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services.[10]

The instructions to the *CPT 2007 Professional Edition* state that it is important to use the related guidelines and other references to ensure the accuracy and quality of medical coding.

> . . . When reporting codes for services provided, it is important to ensure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies.[11]

And the CPT Assistant states the CMS guidelines were jointly developed by the American Medical Association and the Health Care Financing Administration.[12] In addition, the instructions to the *CPT 2007 Professional Edition* state that "[f]or best coding results, you will need to use other reference materials in addition to your coding books" such as medical dictionaries and anatomy books that can be purchased from the American Medical

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[8] Volume II of the Transcript of Proceedings held August 27, 2008, Exhibit 15.

[9] The parties also introduced a portion of *CPT 2007 Standard Edition* as exhibit E to Volume II of the Transcript of Proceedings held August 27, 2008.

[10] Volume II, Transcript of Proceedings held August 27, 2008, Exhibit 21, *CPT 2007 Professional Edition*, Introduction, at xiv.

[11] *Id.*

[12] *Id.*, Ex. 14, p. 5.

Association.[13] Finally, both the 1995 and the 1997 CMS guidelines[14] set forth detailed principles for using and documenting the CPT medical codes.

Moreover, those instructions indicate that the medical services and procedures provided should be adequately documented in the medical records.[15] The publication's Appendix C - Clinical Examples also states that the three components considered in the coding process–history, examination, and medical decision making–must be met *and documented in the medical record* to report a particular level of service.[16] These instructions and statements are important as this dispute is primarily about the interpretation of these various publications and whether the medical records appropriately document the level of services that OHS claims.

Standard of Board review in medical fee disputes.

The Board's review in reviewing the decisions rendered in formal hearings concerning fee disputes is limited to the record presented to the hearing officer. The Act provides that the decision of the Director (which was interpreted in this proceeding by the Kansas Court of Appeals as being the decision of the hearing officer) shall be affirmed unless the decision is not supported by substantial, competent evidence. The Act reads, in part:

> . . . Any decision rendered under this section may be reviewed by the workers compensation board. A party must file a notice of appeal within 10 days of the issuance of any decision under this section. The record on appeal shall be limited only to the evidence presented to the hearing officer. The decision of the director shall be affirmed unless the board determines that the decision was not supported by substantial competent evidence.[17]

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[13] *Id.* at xix.

[14] Volume II of the Transcript of Proceedings held August 27, 2008, Exhibit G.

[15] Volume II, Transcript of Proceedings held August 27, 2008, Exhibit 21, *CPT 2007 Professional Edition*, Introduction, at xiv.

[16] Volume II, Transcript of Proceedings held August 27, 2008, Exhibit 21, *CPT 2007 Professional Edition*, Appendix C at 450.

[17] K.S.A. 44-510j(d)(2).

Both Shorman and the KFMC downgrade OHS's medical codes.

The medical bills and codes in issue were reviewed by Shorman, which has an incentive to modify the CPT codes as its fees are based, at least in part, upon the amounts it saves its clients in downgrading the medical codes. (For the specific changes and downgrades see Appendix I.) But in this instance Shorman was not alone in its conclusions that OHS's medical codes were inappropriate, as the KFMC agreed with 9 of 10 of Shorman's downgrades.

The insurers presented the testimony of Donna McNeill, who works for Shorman. She is a registered nurse, but she is not certified as a medical coder specialist. Ms. McNeill testified she audits medical bills on a daily basis and has worked with the CPT codes since the early 1990s and with the CMS guidelines since these proceedings began. According to Ms. McNeill the 1995 CMS guidelines do not provide detailed guidance regarding medical exams, but she feels the 1997 CMS guidelines do. For each medical bill in issue Ms. McNeill explained why she thought OHS's medical codes should be downgraded, primarily due to the level of examination or the complexity of the medical decision-making process as demonstrated in the medical records. Ms. McNeill confirmed that when Shorman initially downgraded OHS's billing codes, neither the 1995 nor the 1997 CMS guidelines were used. Ms. McNeill was not asked what the appropriate medical code would be using the 1995 CMS guidelines.

Shorman's employee, Michelle Myers, also testified for the insurers. She indicated she did not use the 1995 CMS guidelines for the billings in question and that she does not regularly use them. But she does have experience using the 1997 CMS guidelines, as she had used them in the past when reviewing medical codes for a federal program. Accordingly, Ms. Myers represents she would have used the *CPT* book to begin her analysis and she would have consulted the 1997 CMS guidelines for any necessary clarification. Ms. Myers testified the *CPT* book does not provide the number of elements required to be addressed in an examination to qualify at a certain level (*i.e.,* problem-focused, expanded problem-focused, detailed or comprehensive) and the *CPT* book does not readily define the difference between a limited and an extended examination. Similar to Ms. McNeill, Ms. Myers explained why she believed OHS's medical codes should be downgraded. Ms. Myers testified, in essence, that the levels of examination and decision-making documented in the medical records did not justify OHS's medical codes.

The Division's medical administrator, Dr. Terry Tracy, requested KFMC to review the medical billing codes in issue to determine whether they were appropriate as documented by the medical records. The reports and conclusions of KFMC were entered into the record and further explained in the testimony of its director, Dr. Jeffrey Wheeler. Dr. Wheeler explained that KFMC is a non-profit entity that provides peer review and other review services to its clients, which are primarily Medicare and the State of Kansas. KFMC used

a team approach in reaching its conclusions as it utilized a medical coding specialist (who was not certified), a board-certified occupational medicine specialist (Dr. Ronald Davis), and Dr. Wheeler.

As indicated above, KFMC agreed with Shorman's downgrades regarding nine of the 10 medical codes in issue. Dr. Wheeler explained why KFMC in each instance concluded the medical code should be downgraded. For example, Dr. Wheeler indicated one history did not contain certain elements (that he admitted were not specifically set forth in the *CPT 2007),* which he felt should have been included by custom and practice[18]; documents for another visit did not support a comprehensive examination; records pertaining to another visit did not establish the necessary level of decision-making as the doctor was dealing with a non-weight-bearing bone (although Dr. Wheeler admitted the *CPT 2007* did not make that particular distinction[19]); another history was not comprehensive as it failed to include information regarding the patient's work status, whether restrictions were being followed, the patient's activity level at home, whether the patient was being accommodated at work, and the patient's activity level at home (although the doctor indicated the *CPT 2007* does not specifically address those items[20]); another history was not comprehensive as it did not include the physical demands of the patient's job and did not mention who witnessed the patient's accident and did not include the details of the patient's emergency room visit (although Dr. Wheeler stated there was nothing in the *CPT 2007* about those specific items[21]).

KFMC did not utilize either the 1995 or 1997 CMS guidelines in its evaluation of OHS's billing codes. And much of Dr. Wheeler's disagreement with OHS's medical billing codes was based upon his belief of custom and practice. Dr. Wheeler's testimony confirms that although the CPT codes and guidelines may have been intended to provide a more objective measure to the medical services rendered, there remains a subjective element to applying those codes.

Neither Ms. McNeill nor Ms. Myers nor Dr. Wheeler were asked if OHS's medical codes were appropriate or justified under the 1995 CMS guidelines. Consequently, the greater weight of the evidence indicates that OHS's billing codes complied with the 1995 CMS guidelines. Furthermore, the record indicates those CMS guidelines can be used under the Division's medical fee schedule. Indeed, the Division's medical administrator

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[18] Wheeler Depo. at 79.

[19] *Id*. at 86.

[20] *Id.* at 92.

[21] *Id.* at 100.

advised the parties they could use either the 1995 or 1997 CMS guidelines as a reference for purposes of applying the medical fee schedule.[22]

OHS introduced the testimony of Dr. Daryl Thomas, who is employed by OHS as a senior facility medical manager at one of its eight clinics. Dr. Thomas explained that OHS's doctors prepare a charge ticket following each visit with a patient that contains the medical billing code for that visit. He also testified that OHS's doctors receive medical code training on a regular basis from Lynn Ordal, a certified coder employed by OHS, and also from a consulting service.

Dr. Thomas, whose job entails treating patients 95 percent of the time, reviewed the medical codes in issue and found them appropriate and correct. He explained that he does not note every detail in his examinations. And the term "complete" in his medical notes means he has performed an appropriate detailed exam. Addressing the insurers' implication that complete or comprehensive examinations were unnecessary at the conclusion of a patient's course of treatment, the doctor explained that such examinations were appropriate for assessing risk and complications and for insuring that nothing had been missed.

Lynn Ordal testified she was a medical records auditor and that she was certified as a professional medical coder and also certified in the codes dealing with evaluation and management, which are the types of medical codes in issue. Ms. Ordal has worked for OHS for five years and her job includes reviewing the charge tickets prepared by the doctors to insure the charges are proper and the coding guidelines are met. In addition, she audits contested billings. Moreover, Ms. Ordal audited all the medical bills in issue.

Ms. Ordal testified she was trained to use the 1995 CMS guidelines, which she maintains are more specific than the *CPT* book, which she feels is very general. According to Ms. Ordal medical coders are trained to use the CMS guidelines and no one is trained to rely solely on the *CPT* book. She also testified OHS's malpractice insurer requires use of the 1995 CMS guidelines and those guidelines are the industry standard. Ms. Ordal testified she is not familiar with the 1997 CMS guidelines.

Moreover, Ms. Ordal testified she used an audit tool developed by one of OHS's consultants and that she automatically added three points when analyzing the complexity of decision-making when new patients were involved.

Sandra Soerries also testified on behalf of OHS. She has 27 years experience in medical coding, billing, and claims processing. Ms. Soerries teaches coding compliance to hospitals, physicians, insurers, and even KFMC, among others. She has served on a

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[22] Volume II, Transcript of Proceedings held August 28, 2008, testimony of Donna McNeilll at 377.

national advisory board of an association of professional coders having some 70,000 members and she has testified as a medical coding expert approximately 10 times.

Ms. Soerries reviewed the medical codes in question and using the 1995 CMS guidelines she did not find any instance of excessive coding. She indicated that the 1995 CMS guidelines, which she also maintains are the industry standard, provide that when a doctor says a complete examination has been conducted that is sufficient documentation that the examination was at the comprehensive level. She maintains she was never told or trained to look beyond the doctor's statement concerning the level of an examination.

The record includes evidence supporting both OHS's position and that of the insurers. But the standard of review is whether there is substantial, competent evidence to support the hearing officer's conclusion that OHS's medical billing codes were inflated or, in essence, excessive. And despite any weakness in the testimonies of Dr. Wheeler, Ms. McNeill, and Ms. Myers, there is substantial, competent evidence that the medical records of OHS did not adequately document the medical services provided or the medical codes utilized. Accordingly, the November 14, 2008, Initial Order must be affirmed.

WHEREFORE, the Board affirms the November 14, 2008, Initial Order entered by hearing officer Sandra L. Sharon.

IT IS SO ORDERED.

Dated this _____ day of November, 2010.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

DISSENT

I respectfully disagree with the majority opinion. From the outset the record on appeal to the Board has never been appropriately identified. After the Board was notified that an appeal had been filed, it requested the evidentiary record.[23] The records from hearings are stored by the Director of the Division of Workers Compensation and are not in the possession of the Board. Consequently, the Director of the Division of Workers Compensation, Paula Greathouse, had the Division records custodian provide the Board with a box allegedly obtained from the hearing officer which allegedly contained the evidentiary record. The box presented to the Board that allegedly included the evidentiary record in this case contained documents and transcripts but did not contain an itemization of the contents from either the Department of Administration or the Director's office.[24]

It is significant to note that Hearing Officer Sandra Sharon's Initial Order had merely listed by name three witnesses for respondent and two witnesses for the claimant. The Initial Order did not contain any other itemization to identify the evidence presented to the hearing officer.[25] And the record on appeal to the Board is limited to the evidence presented to the hearing officer. K.S.A. 44-510j(d)(2) provides in pertinent part:

> The record on appeal shall be limited only to the evidence presented to the hearing officer. The decision of the *director* shall be affirmed unless the board determines that the decision was not supported by substantial competent evidence. (Emphasis added).

In order to clarify what evidence had been presented to the hearing officer, the Board requested an agency designation of the record and copied the parties' attorneys, the hearing officer, and the Director of the Division of Workers Compensation.

The hearing officer, Sandra Sharon, did not respond to the request. However, by letter dated December 15, 2008, the Director of the Office of Administrative Hearings for the

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[23] At the time this appeal was filed, these cases were still undocketed. They were not in the Division's computer docketing system for complaints filed pursuant to K.S.A. 44-510j. Thus, there was no way to track the record. And at the time the cases were decided by the Board and that decision was appealed to the Court of Appeals, these cases still had not been docketed by the Division of Workers Compensation.

[24] The haphazard compilation of the contents was demonstrated by the fact that the box included a coffee cup. And there was no indication the coffee cup was somehow an exhibit.

[25] As this is the first time the Board has received an Initial Order from a Department of Administration hearing officer it is unclear if there is a requirement among those hearing officers to itemize the evidentiary record. The workers compensation administrative law judges' decisions routinely contain a listing of the transcripts and exhibits that comprise the evidentiary record.

Department of Administration, Tracy Diel, provided an itemization of the official record. The letter began:

> We are returning the record in the above-mentioned matter. The official record consists of the following numbered files and/or *notebooks included in the box*:

The letter then contained an itemization listing specific cases followed by "Manila File containing paperwork." The number of pages within the manila file folders was not specified. The itemization continued but never specifically identified the "notebooks included in the box."

The letter from the Director of the Office of Administrative Hearings which listed "the official record" was followed by a letter from attorney Greenbaum which read in part:

> I have reviewed the communication forwarded by Tracy Diel, Office of Administrative Hearings, dated December 15, 2008. It does not appear the complete record in this case is described. The items missing include the second day of hearing which took place on August 27, 2008. There were exhibits attached to that hearing. Also missing are the two transcripts of deposition of Dr. Jeffrey Wheeler from the Kansas Foundation taken April 30, 2008 and again on June 5, 2008. There are nine deposition exhibits in the April 30, 2008 deposition. There are eight exhibits in Dr. Wheeler's deposition of June 5, 2008. Said depositions were offered on pages 534 and 535 of the Transcript of Proceedings dated August 27, 2008. The exhibits as presented at hearing are noted in the Transcripts of Proceedings.[26]

The Board forwarded a copy of attorney Greenbaum's letter to the Director of the Office of Administrative Hearings and requested the Director to "[p]lease provide either confirmation that your letter correctly listed the official record or an amended itemization of the official evidentiary record that was considered in this matter by Administrative Hearing Office Sandra Sharon."[27]

The Director of the Office of Administrative Hearings replied by letter dated January 22, 2009, and stated:

> The itemized record which was forwarded to you by the Office of Administrative Hearings (OAH) is all this office has in its possession. OAH does not

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[26] Correspondence from Frederick Greenbaum to Board and Kansas Dept. of Administration, dated December 19, 2008, received December 23, 2008.

[27] Board's letter to Director of Administrative Hearings of January 16, 2009.

> have the second day of the transcript, which is referenced in Mr. Greenbaum's letter dated December 19, 2008. Neither party ordered the transcript of the second day or provided it to this office. Therefore, OAH cannot certify it as being in the record, which this office holds.
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> The depositions which Mr. Greenbaum references in his correspondence, appear to have been introduced into evidence during the second hearing day and became exhibits. They would also be with the transcript of the second day of the hearing. As indicated previously, OAH does not have this transcript. OAH cannot certify the deposition/exhibits and forward to the Board that which it does not have in its possession.
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> Upon receiving Mr. Greenbaum's letter, this office contacted the Division of Workers Compensation about the issues raised. We were told that the depositions which Mr. Greenbaum referenced were in the possession of the Division of Workers Compensation and they would arrange for them to be provided to the Board. It was my understanding this had been done. As for the issue of the transcript, normally this issue is dealt with by the respective parties through the certified court reporter.
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> I hope this clarifies the issue for the Board. I apologize for any confusion.

During the April 7, 2009, oral argument to the Board, counsel for the parties agreed that the record designated by the Director of the Office of Administrative Hearings was incomplete and that the record on appeal to the Board should include the items listed in the December 19, 2008, letter from counsel for appellant. Therefore, the Board requested counsel to "prepare and sign a Joint Stipulation as to the contents of the record in this appeal."[28] The parties filed a Joint Stipulation As to Contents of the Record on May 15, 2009.

At this point there was clearly uncertainty regarding what the evidentiary record was that had been presented to the hearing officer. If the certification from the Director of the Office of Administrative Hearings accurately identified the record, then the hearing officer did not consider evidence included in the parties' stipulation. Conversely, if the parties' stipulation regarding the evidentiary record is accurate, it is difficult to understand how the hearing officer considered evidence and exhibits not in the possession of the Office of Administrative Hearings. In any event, neither the certification from the Director of the Office of Administrative Hearings nor the parties' stipulation addressed the dispositive issue regarding what evidence was presented to and considered by Hearing Officer Sharon.

As noted, the parties stipulated to the record so the matter could proceed before the Board, but it was never confirmed that the hearing officer had considered all of the stipulated

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[28] Board's letter to counsel of April 9, 2009.

evidence.[29] The Board proceeded to hear the appeal but did not address whether there was substantial competent evidence to support the hearing officer's decision, as the Board determined that it did not have jurisdiction to hear an appeal from an initial order and that K.S.A. 44-510j(d)(2) limited the Board's jurisdiction to hear appeals from a final order of the Director.

After the Board entered its decision, the Chairman of the Board received an e-mail from A. J. Kotich, chief counsel for the Department of Labor, requesting the Board to reconsider its decision, change its Order and hear the appeal. The e-mail further threatened a mandamus action against the Board and indicated the Board's Order had placed the Secretary of the Department of Labor, Jim Garner, and Director Greathouse in an untenable position.[30] The Chairman of the Board told the chief counsel that there was no statutory procedure for the Board to re-hear or re-consider a decision and the only statutory remedy to address a Board decision was an appeal to the Court of Appeals.

Director Greathouse (who was not a party to this proceeding) appealed the Board's decision and Mr. Kotich, the chief counsel, represented her on the appeal. Moreover, the three Board Members who signed the Board's Order were named as parties to the appeal. Consequently, two of the Board Members requested that Secretary Garner appoint attorneys to represent them, but when the Board Members were dismissed from the appeal their request for representation was denied by Secretary Garner. The standing for a non-party (the Director) to appeal the Board's decision was neither raised to nor addressed by the Court of Appeals. And it has been recognized that the Board, when ruling on appeals before it, is the agency head.[31] In effect, the Court of Appeals decision was analogous to a default judgment as the Court of Appeals noted the actual parties to the dispute took no position on the Board's interpretation of the statute.

It must be noted that after the Board was created, the Supreme Court adopted rules regarding appeal of the workers compensation board's decisions. Supreme Court Rule 9.04 (b) originally provided that within 10 days of the filing of the notice of appeal, the appellant was required to request in writing to the Board that it certify the record of the proceedings.

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[29] The Director of the Office of Administrative Hearings did not mention Dr. Wheeler in the certification of the record and the hearing officer's Initial Order contains no indication that she considered Dr. Wheeler's deposition testimony or the exhibits attached.

[30] This administrative pressure was problematic as the Secretary appoints the Board Members and two incumbent Board Members had applied for reappointment. This e-mail also raised ethical concerns among the Board Members.

[31] See *Wiehe v. Kissick Construction Co.,* 43 Kan. App. 2d 732, 741, 232 P.3d 866 (2010)*; Herrera-Gallegos v. H & H Delivery Service, Inc.*, 42 Kan. App. 2d 360, 362, 212 P.3d 239 (2009).

But the Director's staff prepared the certification of the record of proceedings. And effective March 11, 1999, Supreme Court Rule 9.04(b) was amended to provide:

> Within ten (10) days of the filing of the notice of appeal, the appellant shall request in writing to *the Director* to certify the record of proceedings. (Emphasis added.)

Accordingly, the Director's staff continued to prepare the certification of the record of proceedings.

As previously noted, the Director stores the records and they are not in the possession of the Board. However, in 2007 Director Greathouse made the administrative decision that the Board's staff would take over certification of the record of proceedings. This required the Board's staff to retrieve the files from the Director and then organize and index the record on appeal for certification to the Court of Appeals. And the Board's staff performed that task for several years. Nonetheless, in this particular case Director Greathouse (who never participated as a party in the original proceedings but somehow became a party to the appeal and in fact was the appellant) removed this file from the Board's staff and had the record prepared by other Division of Workers Compensation staff for the first time since 2007.

The troublesome aspect of this change in the performance of the certification of the record of proceedings, and it has only been for this one case, is that upon remand of the case from the Court of Appeals to the Board, it was discovered that documents were added to the administrative file that were not originally part of the initial evidentiary record provided to the Board. It is not clear how or why these records were added post-appeal when they were not part of the evidentiary record provided to the Board and included items not listed on the parties' stipulation of the record.

Ultimately, the Court of Appeals ruled that the Board did have jurisdiction to hear an appeal of any decision rendered pursuant to K.S.A. 44-510j(d)(2) and when the matter was re-heard by the Board on remand from the Court of Appeals, the parties agreed that Director Greathouse's certified record to the Court of Appeals listed material that was not part of the evidentiary record considered by Hearing Officer Sharon. And those items had not been considered by the Board, as the items were not included in the box allegedly containing the record which was initially provided to the Board.

As an example, when the Board initially received the file it appeared that a private attorney had been appointed as the hearing officer but somehow the file was transferred to the Department of Administration, whose hearing officer entered the initial decision. There was nothing in the administrative file initially received by the Board to document or explain the transfer. Again, it was not until the Board later received the file upon remand from the

Court of Appeals that an agreement between the Department of Labor and the Department of Administration to provide hearing officers for medical bill disputes was included in the record certified to the Court of Appeals by Director Greathouse. Moreover, the file certified to the Court of Appeals by Director Greathouse contained a great many documents that were not included in the parties' stipulation regarding the record. And a large number of the documents were not file stamped by the Division. Interestingly, the certified record also omitted page 2 of the Board's Order that was appealed. This certification of the record just multiplied the confusion regarding the record presented to the hearing officer.

In summary, the undersigned does not believe it has been established what evidentiary record was presented to and considered by Hearing Officer Sharon. Absent a response from the hearing officer listing the evidence presented to her, it is impossible to determine if her decision was based upon substantial competent evidence because it is unclear what evidence was presented. And K.S.A. 44-510j(d)(2) limits the record on appeal to the Board to the evidence presented to the hearing officer. That record changed at every step in the proceedings. Was the record just the witnesses listed in Hearing Officer Sharon's Initial Order? Was the record the list prepared by the Director of the Office of Administrative Hearings? Was it the evidence listed in the parties' stipulation to the Board? Was it the evidentiary record certified by Director Greathouse to the Court of Appeals? Again, there was no confirmation from the hearing officer establishing what evidence had been presented to her. For that reason the undersigned would remand the matter to Hearing Officer Sharon to provide a list of the evidence presented to her and that she considered in making her determination.

Finally, the undersigned would join in Board Member Julie Sample's dissent and would note that there is no dispute that it is acceptable to use either the 1995 or 1997 guidelines when coding the medical bills for payment. In this instance OHS used the 1995 guidelines. The insurers used the 1997 guidelines, and Dr. Wheeler used neither, instead relying upon his experience. There is no evidence that OHS applied the 1995 guidelines incorrectly. And most significantly there is no testimony that if either the 1995 or 1997 guidelines are applied the result should be the same. Absent that evidence, there is no standard upon which to establish prohibited activity. Admittedly, the independent examination by KFMC might ordinarily be persuasive but again they did not use the 1995 guidelines in arriving at their determination and Dr. Wheeler's explanation regarding coding medical bills is akin to tossing a coin to make the determination

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BOARD MEMBER

DISSENT

The undersigned Board Member respectfully joins in the dissent authored by Board Member David Shufelt and also offers the following additional basis for her dissent:

The statute at issue in this case provides that when the *"**director*** finds that a provider or facility has made **excessive** charges or provided or ordered unjustified treatment, services, hospitalization or visits, the provider or facility may, subject to the director's order, receive payment . . . from the carrier, employer or employee for the **excessive** fees . . . ."[32] Unfortunately, nowhere in this statute is there any indication as to what constitutes an "excessive" fee.

This Board is an administrative body which acts in a quasi-judicial capacity. Nonetheless, the constitutional requirements are applicable.[33] "A statute which either requires or forbids the doing of an act in terms so vague that persons of common intelligence must necessarily guess at its meaning and differ as to its application is violative of due process."[34] Economic regulations are unconstitutionally vague if an ordinance or regulation is barren of standards; absence of any ascertainable standards for inclusion and exclusion offends the due process clause.[35] However, a statute is not unconstitutionally vague because there is more than one interpretation of it.[36] There must be something within the statute that conveys a sufficiently definite warning when measured by common understanding and practice to apprise the public of the prohibited activity.[37] And quite obviously, the statute at issue in this case has no touchstone upon which a medical provider can determine whether its charges are "excessive."

The fact that the statute is vague is amply demonstrated by the evidence put forth by the parties in this case. The medical fee statute incorporates the CPT codes. By implication, the CPT code book adopts the 1995 guidelines. It is acceptable to use *either*

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[32] K.S.A. 44-510j(d)(2) (Emphasis added).

[33] *Adams v. Marshall*, 212 Kan. 595, Syl. ¶ 2, 512 P.2d 365 (1973).

[34] *City of Wichita v. Hackett*, 275 Kan. 848, 853, 69 P.3d 621 (2003) (quoting *State v. Dunn*, 233 Kan. 411, 418, 662 P.2d 1286 [1983]).

[35] *City of Kansas City, Kansas v. AIH Waste Management/Incineration, Inc.*, 826 F. Supp 392, 395 (D. Kan. 1993).

[36] *Boatright v. Kansas Racing Comm'n*, 251 Kan. 240, 245, 834 P.2d 368 (1992).

[37] *Id.*

the 1995 or the 1997 guidelines when coding the medical bills for payment.[38] The instructions to *CPT 2007* specifically state to use the *CPT Assistant*, which announced in 1995 the American Medical Association had jointly developed the CMS guidelines for use in coding.[39] And in this instance, OHS used the 1995 guidelines. The insurers presented evidence that the 1997 guidelines indicated many of the bills at issue were "upcoded." But then KFMC's expert (who maintains that OHS "upcoded" their bills) wholly disregarded both versions of the guidelines and relied upon his perceptions of custom and practices, thus injecting a wholly subjective element to the process. It seems problematic that medical providers who must comply with the fee schedule and are likewise told to utilize the 1995 **or** the 1997 guidelines in order to assign the appropriate code can then be subjected to an additional layer of review based upon an individual's own perceptions and personal beliefs. They proceed at their own risk that they will, as here, be found to have charged "excessive" charges for their services. Incidentally, the hearing officer never found the insurer's charges to be "excessive." Thus, she may have had an altogether different definition of what constituted an "excessive" charge. But based on this record or the statute which was applied, it is difficult to know. And that erodes the very fundamental principle encompassed by due process.

For these reasons, I dissent from the majority's opinion.

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BOARD MEMBER

c: George Verscheldon, Attorney for Appellant OHS
Frederick J. Greenbaum, Attorney for appellees KASB Risk Management Services, et al.
Sandra L. Sharon, Presiding Officer, Office of Administrative Hearings, Kansas Department of Administration
Seth Valerius, Acting Director, Division of Workers Compensation, Kansas Department of Labor

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[38] Volume II, Transcript of Proceedings held August 28, 2008, testimony of Donna McNeilll at 377.

[39] Volume II, Transcript of Proceedings held August 27, 2008, Ex. 14.

APPENDIX I

By written stipulation presented to the hearing officer, the parties agreed to the following facts:

1. OHS is a medical service provider with a focus on occupational medicine.

2. Alternative Risk Services (ARS) is a third party administrator and risk management company.

3. The Kansas Municipal Insurance Trust (KMIT) is a self-insured pool of municipalities in the State of Kansas for purposes of workers compensation.

4. The Kansas Association of School Board Workers Compensation Fund, Inc., (KASB) is a fund that has 80 members in its workers compensation pool.

5. On December 13, 2006, OHS provided medical services to Oliver Ison.

6. Mr. Ison was employed by Pavlich, Inc., a member of a self-insured fund administered by ARS.

7. OHS submitted a "Health Insurance Claim Form" for the services provided to Mr. Ison on December 13, 2006.

8. OHS assigned a code of 99214 for the services provided.

9. OHS charged $123.70 for its services based on its code of 99214.

10. OHS's claim form was reviewed by Shorman Solutions, who recommended that OHS should be paid $57.96 based on a code of 99213 under the Kansas Schedule of Medical Fees and in accordance with a CCO PPO Agreement.

11. Shorman provided ARS with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99213. ARS accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

12. On March 14, 2007, OHS provided medical services to Terry Horner.

13. Mr. Horner was employed by the City of Basehor, Kansas, a member of KMIT.

14. OHS submitted a "Health Insurance Claim Form" for the services provided to Mr. Horner on March 14, 2007.

15. OHS assigned a code of 99204 for the services provided.

16. OHS charged $197.92 for its services based on its code of 99204.

17. OHS's claim form was reviewed by Shorman Solutions, who recommended that OHS should be paid $106.74 based on a code of 99203 under the Kansas Schedule of Medical Fees and in accordance with a CCO PPO Agreement.

18. Shorman provided KMIT with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99203. KMIT accepted this recommendation and paid OHS $106.74 for the services reflected in that code.

19. On April 11, 2007, OHS provided medical services to Terry Horner.

20. OHS submitted a "Health Insurance Claim Form" for the services provided to Mr. Horner on April 11, 2007.

21. OHS assigned a code of 99214 for the services provided.

22. OHS charged $123.70 for its services based on its code of 99214.

23. OHS's claim form was reviewed by Shorman Solutions, who recommended that OHS should be paid $57.96 based on a code of 99213 under the Kansas Schedule of Medical Fees and in accordance with a CCO PPO Agreement.

24. Shorman provided KMIT with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99213. KMIT accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

25. On May 2, 2007, OHS provided medical services to Terry Horner.

26. OHS submitted a "Health Insurance Claim Form" for the services provided to Mr. Horner on May 2, 2007.

27. OHS assigned a code of 99214 for the services provided.

28. OHS charged $123.70 for its services based on its code of 99214.

29. OHS's claim form was reviewed by Shorman Solutions, who recommended that OHS should be paid $57.96 based on a code of 99213 under the Kansas Schedule of Medical Fees and in accordance with a CCO PPO Agreement.

30. Shorman provided KMIT with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99213. KMIT accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

31. On January 16, 2007, OHS provided medical services to Scott Parsley.

32. Mr. Parsley was employed by Kansas City Kansas Community College, a member of KASB.

33. OHS submitted a "Health Insurance Claim Form" for the services provided to Mr. Parsley on January 16, 2007.

34. OHS assigned a code of 99204 for the services provided.

35. OHS charged $197.92 for its services based on its code of 99204.

36. OHS's claim form was reviewed by Shorman, who recommended that OHS should be paid $118.60 based on a code of 99203 under the Kansas Schedule of Medical Fees.

37. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99203. KASB accepted this recommendation and paid OHS $118.60 for the services reflected in that code.

38. On February 16, 2007, OHS provided medical services to Amy Smith.

39. Ms. Smith was employed by Kansas City Community College, a member of KASB.

40. OHS submitted a "Health Insurance Claim Form" for the services provided to Ms. Smith on February 16, 2007.

41. OHS assigned a code of 99214 for the services provided.

42. OHS charged $123.70 for its services based on its code of 99214.

43. OHS's claim form was reviewed by Shorman, who recommended that OHS should be paid $57.96 based on a code of 99213 under the Kansas Schedule of Medical Fees and in accordance with a CCO PPO Agreement.

44. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99213. KASB accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

45. On June 11, 2007, OHS provided medical services to Stacy Kahnt.

46. Ms. Kahnt was employed by Troy Public Schools USD 429, a member of KASB.

47. OHS submitted a "Health Insurance Claim Form" for the services provided to Ms. Kahnt on June 11, 2007.

48. OHS assigned a code of 99214 for the services provided.

49. OHS charged $123.70 for its services based on its code of 99214.

50. OHS's claim form was reviewed by Shorman, who recommended that OHS be paid $57.96 based on a code of 99213 under the Kansas Schedule of Medical fees and in accordance with a CCO PPO Agreement.

51. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS should be paid based on a code of 99213. KASB accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

52. On January 24, 2007, OHS provided medical services to Danette Michaels.

53. Ms. Michaels was employed by Kansas City Kansas Community College, a member of KASB.

54. OHS submitted a "Health Insurance Claim Form" for the services provided to Ms. Michaels on January 24, 2007.

55. OHS assigned a code of 99204 for the services provided.

56. OHS charged $197.92 for its services based on is code of 99204.

57. OHS's claim form was reviewed by Shorman, who recommended that OHS be paid $118.60 based on a code of 99203 under the Kansas Schedule of Medical Fees.

58. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS be paid based on a code of 99203. KASB accepted this recommendation and paid OHS $118.60 for the services reflected in that code.

59. On February 2, 2007, OHS provided medical services to Danette Michaels.

60. OHS submitted a "Health Insurance Claim Form" for the services provided to Ms. Michaels on February 2, 2007.

61. OHS assigned a code of 99214 for the services provided.

62. OHS charged $123.70 for its services based on its code of 99214.

63. OHS's claim form was reviewed by Shorman, who recommended that OHS be paid $57.96 based on a code of 99213 and the Kansas Schedule of Medical Fees.

64. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS be paid based on a code of 99213. KASB accepted this recommendation and paid OHS $57.96 for the services reflected in that code.

65. On May 4, 2007, OHS provided medical services to Teresa Truman.

66. Ms. Truman was employed by Kansas City Kansas Community College, a member of KASB.

67. OHS submitted a "Health Insurance Claim Form" for the services provided to Ms. Truman on May 4, 2007.

68. OHS assigned a code of 99214 for the services provided.

69. OHS charged $123.70 for its services based on its code of 99214.

70. OHS's claim form was reviewed by Shorman, who recommended that OHS be paid $64.40 based on a code of 99213 and the Kansas Schedule of Medical Fees.

71. Shorman provided KASB with an explanation of benefits reflecting its recommendation that OHS be paid based on a code of 99213. KASB accepted this recommendation and paid OHS $64.40 for the services reflected in that code.