STATE OFFICE OF ADMINISTRATIVE HEARINGS
300 West 15th Street, Suite 502
Austin, Texas 78701

SOAH DOCKET NO. 453-03-2381.M4
MDR Tracking No: M4-02-3276-01

CONTINENTAL INSURANCE CO., Petitioner	§	**BEFORE THE STATE OFFICE**
VS.	§	**OF**
PAUL T. GEIBEL, M.D., AND ROBERT M. WARD, M.D., Respondents	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Continental Insurance Company (Carrier) requested a hearing before the State Office of Administrative Hearings (SOAH) to contest a Texas Workers' Compensation Commission (Commission) Medical Review Division (MRD) decision authorizing payment to Dr. Paul T. Geibel and Dr. Robert M. Ward, Respondents, for surgical procedures pursuant to CPT Codes 22630-51, 63047-80, and 22630-51-80. The MRD determined that the Carrier should pay the additional amount of $2,917.50 for these procedures. This decision agrees with the MRD and orders the Carrier to pay the additional amount of $2,917.50 plus interest for the contested surgical procedures.

I. PROCEDURAL HISTORY

Administrative Law Judge (ALJ) Nancy N. Lynch convened a hearing on April 28, 2003. Evidence and argument were submitted. The Carrier was represented by Erin Shanley, attorney, and Respondents were represented by Dr. Paul Geibel. The record was left open for additional documents and written arguments until May 23, 2003. Notice and jurisdiction were not disputed and are addressed in the findings of fact and conclusions of law without discussion here.

II. DISCUSSION

A. Applicable law

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEXAS LABOR CODE (the Act) § 408.021(a). "Health care" includes all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services. The Act, § 401.011(19).

The Carrier has the burden of proof in this proceeding because it is challenging the decision of TWCC's MRD. 28 TEX. ADMIN. CODE (TAC) § 48.21(h).

B. The evidence

The evidence consists of Carrier's Exhibits 1-6, including records of the request for medical dispute resolution by Dr. Paul T. Geibel and Dr. Robert M. Ward, the MRD's Findings and Decision, insurance claim forms, the Carrier's explanation of benefits forms, two pages reflecting payments by the Carrier, and 48 pages of Claimant's medical records. The Carrier also submitted several pages from coding protocols and some previous SOAH decisions that had ordered providers to refund certain payments already made by carriers. Respondents submitted an updated table of disputed services reflecting the items that remained in dispute after they received an additional payment from the Carrier. Dr. Geibel also submitted testimony and argument by telephone.

C. The facts

Claimant sustained a work-related injury to his lower back and left knee on __, when he fell down a series of stairs while painting. He experienced back pain and left knee pain. He has had an epidural injection, extensive physical therapy and work hardening programs for his lower back and knee with no lasting improvement. He also has had knee surgery.

Claimant's history of treatment has been as follows:

- September 23, 1996 -- Claimant consulted Dr. Geibel at South Texas Spinal Clinic. His primary complaint was "constant back pain radiating to his left buttock and posterolateral foot and plantar aspect with a tingling numb sensation." His symptoms were aggravated by any sitting, bending, lifting, standing or walking more than 10 minutes. He was able to obtain some relief by lying down and applying heat. On a scale of 1 to 10, he reported his pain as an 8. Carrier's Ex. 6, p. 1.

- November 16, 1996 -- Claimant had a lumbar laminectomy at the L4-L5 level on November 13, 1996. He continued to have pain.

- August 12, 1998 -- A lumbar provocative discography at the L4-5 and L5-S1 lumbar discs was performed to further establish the source of the continuing pain in Claimant's lower back, left buttock, left posterior calf, and left foot. The discogram revealed an abnormal disc contrast pattern at L4-L5 during which the patient experienced pain in his left buttock. At L5-S1, the disc contrast appeared normal and the patient did not report or display pain. Carrier's Ex. 6, p. 4.

  A CT scan of L3 to S1 immediately followed the discogram. That test showed a broad based radial annular tear of the L4-5 disc extending from the left poster lateral annulus to the right par central annulus. In addition, a small focal extravasation of contrast through the annulus into the epidural space was reported, as well as abnormal soft tissue in the ventral epidural and left lateral epidural space. The report noted it was not possible to determine whether this material was residual granulation tissue, residual disc fragment, or free fragment. Carrier's Ex. 6, pp. 6-7.

The L3-4 level revealed a broad based disc bulge, facet spurring and ligamentum flavum buckling causing mild--moderate central spinal stenosis and subarticular recess stenosis at that level. The report noted that L3-4 apparently had not been injected during the discogram to determine if it was a cause of the patient's pain. Carrier's Ex. 6, pp. 6-7.

- April 24, 2000 -- Report of MRI of Claimant's lumbar spine revealed no abnormality at the L3-4 level. The L4-5 level displayed previous surgical changes with some scarring with bilateral laminectomy defects. Slight enhancement, compatible with scarring, was reported along the left lateral aspect of the thecal sac and adjacent to both nerve root sheaths. No recurrent disc herniation or free disc fragment was identified. Slight narrowing of the lower portion of both neural foramina and slight annular bulging were reported. Carrier's Ex. 6, pp. 8-9.

- May 16, 2000 -- Claimant was again examined by Dr. Geibel. The MRI revealed epidural scar with L4-5 recurrent HNP. Claimant reported pain radiating to his left buttock and leg with increased symptoms: difficulty standing, walking, bending and lifting, and some difficulty sleeping. These, according to Dr. Geibel's notes were symptoms of lumbar radiculopathy from an underlying L4-5 HNP. He has some degree of recurrence with post laminectomy instability. Dr. Geibel recommended an L4-5 level decompressive laminectomy and interbody fusion due to non-improvement with medical treatment. Carrier's Ex. 6, p. 10.

- September 1, 2000 -- Claimant returned to Dr. Geibel for re-evaluation. He was still having significant back pain, buttock and left leg pain down to his lateral calf and ankle. Dr. Geibel noted Claimant continues to be "symptomatic from an L4-5 HNP with post laminectomy instability." Claimant said he wanted to go ahead with surgery and was waiting approval for the operation. Carrier's Ex. 6, p. 13.

- September 18, 2000 -- Preauthorization letter from TWCC to Dr. Geibel. It indicated that the second opinion doctor agreed with the recommendation for spinal surgery. It also indicated it was "your preauthorization for spinal surgery and is valid for one year from the date the letter is issued." Carrier's Ex. 6, p.14.

- April 16, 2001 -- Pre-op physical showed Claimant had no change from the September pre-op (when surgery had been postponed because Claimant had a high fever and respiratory infection). Claimant had no chronic health problems except for his back pain. He got no relief from laminectomy done in November 1996. Claimant was diagnosed as depressed secondary to chronic pain. Carrier's Ex. 6, pp. 15-16.

- April 25, 2001 -- Operative Report indicates Paul T. Geibel, M.D., was the surgeon; Robert Ward, M.D. was the assistant surgeon; and Timothy Orihel, M.D., was the anesthesiologist. The preoperative diagnoses were:

    - L4-5 recurrent herniated nucleus pulposus with radiculopathy.
    - L3-4 and L4-5 lateral recess stenosis with radiculopathy.
    - L4-5 post laminectomy, segmental instability.
    - Status post L4-5 laminotomy, diskectomy.

The postoperative diagnoses were the same.

The operation performed included the following procedures:

- Decompressive lumbar laminectomy at L3-4, L4-5.

- Bilateral medial facetectomies for L3-4, L4-5, with bilateral L4 and L5 nerve root foraminotomy and subarticular decompression B neurolysis.
- L4-5 subtotal diskectomy.
- L4-5 posterior lumbar interbody fusion with iliac crest bone graft.
- Insertion bilateral CCR interbody cages 10 x 22 mm L4-5 level.
- Posterior pedicle instrumentation L4-5 with MA pedicle instrumentation 40 mm x 7.5 mm screws bilaterally.
- Bilateral L4-5 posterolateral intertransverse fusion with iliac crest bone graft.
- Left posterolateral iliac bone graft.
- Epidural Duramorph 4 cc.

Carrier's Ex. 6, pp. 23-26.

D. MRD Order

The MRD ordered the Carrier to pay additional reimbursement in the amount of $2,917.50 plus interest for the following services:

- CPT code 22630-51 lumbar arthrodesis -- Dr. Geibel - $1,650.00
- CPT code 22630-51-80 lumbar arthrodesis -- Dr. Ward - $825.00
- CPT code 63047-80 laminectomy –
- Dr. Ward - $442.50

E. The parties' positions

1. The coding issues

Carrier argued that the Complete Global Service Data for Orthopaedic Surgery 2002, volume 1, CPT code 22630, provides that arthrodesis is included in the reimbursement for laminectomy. Therefore, Carrier argues, neither the surgeon nor the assistant surgeon should have billed under separate CPT codes for arthrodesis. Carrier also cited the 2003 Coding Companion for Neurosurgery/ Neurology, p. 268; and Spine Coding Illustrated, p. 34. Carrier's Ex. 7, 8 and 9.

Dr. Geibel argued that the CPT code provides an exception that is applicable in this case: when laminectomy is required for decompression, it is not bundled with CPT code 22630. The Claimant's laminectomies were performed because of lumbar stenosis with recurrent herniated nucleus pulposus with radiculopathy. This is clearly documented in the operative report. The primary procedure performed was CPT code 63047. (CPT code 63048 is used for the two additional segments.)

CPT code 22630 was appropriate for the arthrodesis because the laminectomies were for decompression. When the laminectomy is for decompression, the arthrodesis or fusion is not bundled with the laminectomy. The CPT code 22630 description reads:

> Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar.

Dr. Geibel also pointed out that the laminectomies and the arthrodesis were performed on different segments of Claimant's spine.

CPT codes 63047, 63048:	These codes were used for three segmental laminectomies starting with lumbar vertebral segment L3 CPT (code 63047), another at L4, and another at L5 (CPT code 63048).
CPT code 22630:	This code was used for a posterior interbody fusion that was performed on lumbar interspace L4-5.

A letter from Anna De La Fuente, RHIT, CCS-P, of the South Texas Spinal Clinic, dated January 3, 2002, explained that CPT code 63047, 63048, and 22630 were not performed on the same vertebrae and, therefore, both should be paid. Carrier's Ex. 1, unnumbered pp. 3-4.

ALJ's Analysis and Conclusion

The ALJ concludes that the Provider used the CPT codes appropriately. The exception to the global rule cited by Carrier is when laminectomy is performed for decompression. Then it is appropriate to code the laminectomy and the arthrodesis separately. Interbody arthrodesis CPT code 22630 clearly does not include decompression. This surgery was primarily for decompression. This is supported, not only by Dr. Geibel's testimony but also by Claimant's medical records that reveal significant and long-term back, buttock, and left leg pain. The operative report also indicates that decompressive laminectomies were performed, as well as a posterior lumbar interbody fusion.

Further, the codes actually applied to different segments of Claimant's spine. The arthrodesis procedure that was performed on lumbar interspace L4-5 was coded as CPT code 22630. This procedure was not a included with the laminectomies performed on lumbar vertebral segments L3, L4, and L5 and coded as CPT code 63047 and 63048 (two additional segments). It was appropriate to code them separately.

2. Carrier's other issues

The Carrier also challenged all payments it had made to the assistant surgeon because, it alleged, his services had not been appropriately documented in compliance with the Medical Fee Guideline (MFG). At a minimum, Carrier requested a refund or offset of the $442.50 for CPT Code 63047-80. Carrier also asserted that the preauthorization did not include the procedure done at L3-4.

Dr. Geibel protested that these were new arguments being "put on the table" at this point. The Carrier had not raised either of these issues in its explanation of benefits or before the MRD. Dr. Geibel attempted to offer responses but he clearly had not prepared to do so.

ALJ's Analysis and Conclusion

It is generally established at SOAH that a Carrier is limited to the explanations it provides when denying reimbursement in its explanation of benefits and cannot raise new reasons before the MRD or at SOAH. *See, e.g.*, Docket No. 453-02-2026.M5 (June 19, 2002, ALJ Kilgore); Docket No. 453-01-0309.M5 (February 7, 2001, ALJ Doherty); Docket No. 453-97-0973.M4 (May 14, 1998, ALJ Card); Docket No. 453-96-1446.M4 (Nov. 12, 1996, ALJ Corbitt).

The ALJ found nothing in the explanation of benefits submitted to Dr. Geibel or Dr. Ward or in documents submitted to the MRD that indicated Carrier had previously raised these issues. Therefore, the ALJ concludes these issues were waived. The ALJ also concludes that the SOAH decisions submitted by Carrier regarding refunds and offsets were not applicable in this case.

III. FINDINGS OF FACT

1. An injured worker (Claimant) suffered a compensable injury when he fell down a series of stairs on ___, while he was painting.

2. Continental Insurance Company (Carrier) is responsible for the workers' compensation insurance coverage of Claimant's employer when he was injured.

3. Claimant's fall caused immediate lower back, leg, and knee pain.

4. Claimant has had an epidural injection, extensive physical therapy, and a work hardening program with no lasting improvement.

5. Claimant first consulted Dr. Paul Geibel at South Texas Pain Clinic in September 1996.

6. Claimant had a lumbar laminectomy at the L4-5 level in November 1996, but he continued to have pain.

7. In August 1998, he had a lumbar discography immediately followed by a CT scan from L3 to S1. These diagnostic tests revealed abnormalities in the L3-4 and L4-5 discs.

8. In May 2000, Dr. Geibel examined Claimant again. Claimant reported increased difficulty standing, walking, bending and lifting and some difficulty sleeping. Dr. Geibel recommended a L4-5 level decompressive laminectomy and interbody fusion because Claimant had not improved with medical treatment.

9. In September 2000, Claimant told Dr. Geibel he wanted to proceed with surgery.

10. A second opinion doctor agreed with the recommendation for spinal surgery, and the surgery was preauthorized by letter to Dr. Geibel dated September 18, 2000.

11. Dr. Geibel performed surgery on Claimant in April 2001, assisted by Dr. Robert Ward.

12. The surgery included segmental decompressive lumbar laminectomies at L3, L4, and L5.

13. The surgery was properly coded as CPT code 63047 (for the first segment) and 63048 (for the next two segments) for Dr. Geibel, the surgeon. The same codes with the -80 modifier were appropriate codes for the assistant surgeon.

14. The surgery also included a posterior interbody fusion, or arthrodesis, performed on lumbar interspace L4-5, coded properly using CPT code 22630.

15. Reimbursement for the charges submitted under CPT codes 63047-80, 22630-51, and 22630-51-80 is appropriate.

16. Carrier had not based its denial of payment to the assistant surgeon on lack of documentation of the medical necessity of the assistant surgeon, of his time in the operating room, or on the lack of preauthorization of any portion of the surgical procedure in its explanation of benefits forms or before the MRD.

17. The MRD found that Drs. Geibel and Ward were entitled to reimbursement in the amount of $2,917.50 plus interest for CPT codes 22630-51, 22630-51-80, and 63047-80.

18. Carrier timely appealed the MRD decision.

19. Notice of the hearing on the appeal was sent to the parties by the Commission on March 7, 2003. The notice informed the parties of the date, time, and location of the hearing, a statement of the matters to be considered, the legal authority under which the hearing would be held, and the statutory provisions applicable to the matters to be considered.

20. The State Office of Administrative Hearings (SOAH) hearing was held on April 28, 2003, and the record closed on May 23, 2003.

IV. CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

4. As Petitioner, the Carrier has the burden of proof in this matter. 28 TEX. ADMIN. CODE (TAC) §148.21(h).

5. Carrier waived its complaints about lack of documentation regarding the assistant surgeon and the lack of preauthorization of the surgical procedure done at L3-4 because it had not raised these issues in its explanation of benefits forms or before the MRD.

6. Based on the above findings of fact and conclusions of law and pursuant to § 408.021(a) of the Act, Petitioner's request for relief should be denied and Paul T. Geibel, M.D., should receive the amount of $1,650.00 plus interest, and Robert M. Ward, M.D., should receive the amount of $1,267.50 plus interest, for surgery performed on Claimant on April 25, 2001.

ORDER

IT IS, THEREFORE, ORDERED THAT Continental Insurance Company pay to Paul T. Geibel, M.D., the amount of $1,650.00 plus interest, and to pay Robert M. Ward, M.D., the amount of $1,267.50 plus interest, for a total reimbursement of $2,917.50 plus interest related to Claimant's surgery performed on April 25, 2001.

SIGNED, October 7, 2003.

NANCY N. LYNCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS