DOCKET NO. 453-03-2383.M5
MDR Tracking Number: M5-02-2766-01

CITY OF HOUSTON	§	**BEFORE THE STATE OFFICE**
	§	
v.	§	**OF**
	§	
ERIC H. SCHEFFEY, M.D.	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

After the City of Houston (Carrier) denied payment for spinal surgery, Eric H. Scheffey, M.D., (Provider), appealed to the Texas Workers' Compensation Commission's Medical Review Division (MRD). MRD ordered payment for the services, finding the surgery had been preauthorized. At the hearing on the Carrier's appeal, the Carrier argued that the services were not medically necessary, and the Provider attacked the argument based on the preauthorization. This decision finds that the principal procedures were preauthorized and should be reimbursed; other surgical procedures were medically necessary; and even though some billed CPT codes did not include a required modifier, the omission was corrected in the record, and there was no evidence of a negative impact caused by the omission. Consequently, the Carrier is ordered to reimburse the Provider $12,291.50.

I. Procedural History, Notice, and Jurisdiction

At the hearing on April 29, 2003, attorney Mark Sickles represented the Carrier, and Linda Mallet represented the Provider. The record closed on the same day but was subsequently reopened by the administrative law judge (ALJ). In the ALJ's order, the parties were instructed to address the applicability to this case of certain Commission rules and to discuss what appeared to be a duplicate billing charge. The record finally closed on July 16, 2003. (This case was heard together with Docket No. 453-03-2382.M4, concerning the assistant surgeon's fees.)

II. Discussion

Ms. Mallet, who works in the accounts receivable, billing, and collection department for East Harris County Orthopedic Associates, was the only witness at the hearing. Five exhibits were admitted into evidence.

The workers' compensation claimant sustained a compensable back injury on ___. By March 29, 1999, he was at maximum medical improvement and received a five percent impairment rating. Nevertheless, the Carrier preauthorized lumbar surgery, which was performed on February 5, 2002. The record contains more than one preauthorization statement. The first, dated January 24, 2002, preauthorizes CPT codes 63047, 22630, and 22842 with a two-day inpatient stay.[1] The second preauthorization form, dated February 13, 2002, preauthorizes lumbar surgery with no CPT codes specified and inpatient dates from January 31, 2002, through an unspecified date. Finally, a preauthorization referral form, dated February 25, 2002 (approximately 20 days after the claimant's surgery), preauthorizes CPT codes 63047 and 22630 with an inpatient stay from January 31, 2002, through February 11, 2002.[2]

The Provider requested reimbursement for the surgical services under the following CPT codes. The Carrier paid nothing for these charges and used denial code "V" on its explanations of benefits, which reflected reliance on a peer review to find the treatments were medically unreasonable and unnecessary.[3]

The CPT codes in bold were specifically preauthorized:

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[1]Ex. 4, p. 33.

[2]Ex. 5, p. 28.

[3]Ex. 5, p. 68.

CPT Code	Medical Fee Guideline Description of CPT Code	Billed	Maximum Allowable Reimbursement (MAR)
63047 L2	Lumbar B posterior extradural laminotomy or laminectomy for exploration or decompression of neural elements or excision of herniated intervertebral discs	$4,000.00	$3,540.00
63048 S1	Each additional segment, cervical, thoracic or lumbar	900.00	708.00[4]
22630 L3	Arthrodesis, posterior interbody technique, with local bone or bone allograft and/or internal wire fixation, lumbar	3,500.00	1,650.00[5]
22625 L3	Arthrodesis, lateral transverse process technique, with local bone or bone allograft and/or internal wire fixation, lumbar	3,050.00	1,264.50
22650 L4	Arthrodesis, posterior, posterolateral or lateral transverse process technique, each additional interspace	1,300.00	637.00
22650 L4	Arthrodesis, posterior, posterolateral or lateral transverse process technique, each additional interspace	1,950.00	637.00
22842	Segmental fixation (*e.g.*, pedicle fixation, dual rods with multiple hooks and subliminal wires)	5,983.00	3,400.00
20975	Invasive (operative)	500.00	455.00
Total			12,291.50

Peer Reviews Regarding Medical Necessity

Two discograms were performed on the claimant in 2001. The first showed herniations at L1-L2 and L2-L3.[6] The second showed herniation at L5-S1 with minimal nuclear flattening and bulging. An October 22, 2001, MRI showed no herniation.[7]

Both second opinion doctors consulted in 1999 regarding an earlier proposed lumbar surgery

[4]According to the Commission's Surgery Ground Rules 1.D. and 1.E., CPT Codes 63048, 22650, 22842, and 20975 are not to be reduced under provisions relating to global services because an appropriate second-procedure reduction has already been calculated into the MAR.

[5]When this is the primary procedure, the MAR is $3,300. The Surgery Ground Rules, in I.D.1, require a 50% reduction of the MAR for secondary or subsequent procedures.

[6]Ex. 1, pp. 38-39.

[7]Ex. 1, pp. 31-33.

disagreed with the Provider's surgical plan. Casey Cochran, D.O.,[8] noted that there were no sensory deficits in the claimant's legs. He determined that the claimant had a soft tissue lumbar sprain or strain, but because of the claimant's long-term complaints of pain, he recommended an evaluation at a multi-disciplined pain management program.[9]

On January 2, 2001, Gary Freeman, M.D., Diplomate, American Board of Orthopaedic Surgery, examined the claimant and determined that he had preexisting degenerative disc disease and any further treatment would be more injurious to him than curative. Dr. Freeman interpreted an August 8, 1998, MRI as showing "only multiple levels of slight bulging with dessication." He assessed a zero percent impairment rating and also found the claimant was physically capable of employment.[10]

Operative Report

According to the February 5, 2002, operative report, Dr. Scheffey's preoperative diagnoses of the claimant included disc herniations at L3-L4, L4-L5, and L5-S1; spinal stenosis; lateral recess stenosis at L2-S2; bowel and bladder dysfunction; chronic low back pain with lumbar radiculopathy; failed conservative treatment; and areas of fibrosus pseudoarthrosis at S1-S2. Postoperatively, the report lists the same diagnoses and adds "compression to S2."[11]

The Provider listed the surgical procedures as:

- bilateral laminectomy at L2-L3, L3-L4, L4-L5, L5-S1, and S1-S2 with foraminotomies at L2, L3, L4, L5, S1 and S2 bilaterally;
- excision herniated lumbar disc L3-L4, L4-L5, L5-S1;
- sacroiliac graft;
- anterior fusion from posterior approach L3-L4, L4-L5, L5-S1 using 13 X 24 Ray cages;
- exploration of fusion area with excision of fibrosis pseudoarthrosis S1-S2;
- lateral transverse fusion L3-L4, L4-L5, L5-S1, S1-S2;
- EBI bone stimulation of lateral transverse fusion L3-S2; and
- posterolateral posterior facet fusion L3-L4, L4-L5, L5-S1, S1-S2.

The Provider also included a three-page narrative that describes the procedures in detail.

Parties' Arguments

Citing the MRI, discograms, and peer reviews, the Carrier argued that the services were not medically necessary. The Carrier further opposed reimbursement for certain codes because the Provider did not include a modifier to show the laminectomy was followed by arthrodesis, as required by Surgery Ground Rule I(E)(2)(b).

The Provider challenged the Carrier's arguments because the surgery was preauthorized. The Provider also argued that it correctly billed twice for CPT code 22650-L4 because the surgery was for different levels.

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[8]Dr. Cochran is certified by the American Board of Independent Medical Examiners and a fellow of the American Academy of Disability Evaluating Physicians.

[9]Ex. 1, pp. 24-30.

[10]Ex. 1, pp. 20-23; Ex. 5, pp. 37-40.

[11]Ex. 5, pp. 59-63.

In its written arguments, the Provider clarified the amount requested for CPT code 22650. MRD had included an amount that was too high and did not recognize a reduction for a second procedure during a surgical session.

III. Analysis

CPT Codes 63047, 22630, and 22842 Were Preauthorized

Commission rule 28 TAC § 133.301 prohibits retrospective review of medical necessity for services that have been preauthorized.[12] Because these codes were preauthorized and the work was adequately documented, the Provider should be reimbursed for the services.

The Preauthorization Request and Medical Necessity

Commission rule 28 TAC § 134.600(h) requires preauthorization of all non-emergency health care involving inpatient hospital admissions, "including the principal scheduled procedure(s) and the length of stay." In the Commission's response to comments regarding a proposed change to the rule, the Commission said the term principal refers to the "main" procedure. The health care provider is not required to enumerate every procedure to be performed during the admission.[13]

The Provider's first preauthorization request gave the Carrier adequate notice of his intention to perform a one-level laminectomy and arthrodesis with segmental fixation and for the claimant to have a two-day hospital stay. After the surgery, the Carrier extended preauthorization to allow for a longer in-patient hospital stay, but it did not preauthorize services under additional CPT codes. Because only three CPT codes were preauthorized, it is appropriate to consider whether the preauthorized services were medically necessary.[14]

The peer reviewing doctors determined that no surgery was indicated because the claimant had no sensory deficits in his legs and because tests showed he had only multiple levels of slight bulging with dessication, most likely from degeneration. Even so, the Provider observed large disc herniations at three levels, and no expert witness highlighted any error in the Provider's judgement, after surgery had commenced.[15] Therefore, the ALJ finds the Carrier failed to meet its burden of proving the additional surgical procedures were not medically necessary.

C *Improper Coding*

The Provider's bill failed to include modifiers. Surgery Ground Rule I(E)(2)(b) provides, in pertinent part:

Unless otherwise identified in the CPT descriptor:

(1) Bilateral procedures that are performed at the same operative session shall be identified by the appropriate five digit code describing the first procedure. The

[12]Commission rule 28 TAC §133.206 formerly required a second opinion prior to surgery. The requirement was deleted from the rule, effective January 1, 2002.

[13]Ex. 6, p. 7.

[14]*See* Decision and Order, Docket Nos. 453-02-1857.M5 and 453-02-2031.M5, issued November 12, 2002.

[15]In his preoperative medical reports, the Provider indicated a diagnosis of herniations at L3-L4, L4-L5, and L5-S1. But, there was no evidence that the preauthorization requests were cryptic by design or to conceal the true extent of the proposed surgery.

second (bilateral) procedure is identified by adding modifier -50 to the procedure.

(1) Fusions, . . . are considered bilateral, therefore, no additional reimbursement shall be allowed.

The CPT codes used in this case have distinctive descriptions for lateral and posterior fusions. Thus, the ALJ assumes reimbursement for both lateral and posterior levels is appropriate. The Surgery Ground Rules describe CPT codes 63048, 22650, 22842, and 20975 as already having a second-procedure reduction calculated into the MAR. In the ALJ's opinion, the use of a modifier with these procedures would be duplicative.

The remaining CPT codes are 22630, posterior arthrodesis, and 22625, lateral arthrodesis, for which the Provider billed the full MAR rate, rather than the amount allowed when the procedures are secondary or subsequent procedures. In an earlier decision concerning this same Provider, ALJ Craig Bennett found that the Provider's incorrect billing should defeat his claim.[16] However, in that case, the Provider refused to correct its coding and billing after being an opportunity to do so. In this case, MRD and the Provider corrected the amounts requested. As a result, there is no longer confusion about the appropriate reimbursement amount and no evidence of a negative impact to the Carrier based on the incorrect billing.

In the Provider's operative report, he documented both lateral and posterior fusions, and as amended, the bill appropriately covers those levels. Therefore, the MARs shown on the chart on pages two and three reflect correct billing, and the Provider should be reimbursed for his services at the total rate of $12,291.50.

IV. Findings of Fact

1. The claimant sustained a compensable back injury on ___, when his employer had workers' compensation insurance coverage with the self-insured City of Houston (Carrier).

2. Commission rule 28 TAC § 134.600(h) requires preauthorization of all non-emergency health care involving inpatient hospital admissions, "including the principal scheduled procedure(s) and the length of stay."

3. The reference to the principal procedure mentioned in the preceding Finding of Fact refers to the "main" procedure; the health care provider is not required to enumerate every procedure to be performed during the admission.

4. Based upon the request of Eric H. Scheffey, M.D., (Provider), the Carrier preauthorized lumbar surgery, including CPT codes 63047, 22630, and 22842.

5. The Provider performed the surgery on February 5, 2002.

[16]Decision and Order, Docket Nos. 453-02-1857.M5 and 453-02-2031.M5, issued November 12, 2002.

6. The Provider requested reimbursement for the surgical services under the following CPT codes:

CPT Code	Medical Fee Guideline Description of CPT Code	Billed	Maximum Allowable Reimbursement (MAR)
63047 L2	Lumbar B posterior extradural laminotomy or laminectomy for exploration or decompression of neural elements or excision of herniated intervertebral discs	$4,000.00	$3,540.00
63048 S1	Each additional segment, cervical, thoracic or lumbar	900.00	708.00
22630 L3	Arthrodesis, posterior interbody technique, with local bone or bone allograft and/or internal wire fixation, lumbar	3,500.00	1,650.00
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22650 L4	Arthrodesis, posterior, posterolateral or lateral transverse process technique, each additional interspace	1,300.00	637.00
22650 L4	Arthrodesis, posterior, posterolateral or lateral transverse process technique, each additional interspace	1,950.00	637.00
22842	Segmental fixation (*e.g.*, pedicle fixation, dual rods with multiple hooks and subliminal wires)	5,983.00	3,400.00
20975	Invasive (operative)	500.00	455.00
Total			12,291.50

7. The Carrier paid nothing for these charges and used denial code "V"on its explanations of benefits, which reflected reliance on a peer review to find the treatments were medically unreasonable and unnecessary.

8. The Provider appealed to the Texas Workers' Compensation Commission's Medical Review Division (MRD), and by decision issued January 15, 2003, MRD ordered payment for the services, finding the surgery had been preauthorized.

9. By letter dated January 23, 2003, the Carrier timely appealed to the State Office of Administrative Hearings (SOAH).

10. The hearing notice on the appeal was sent January 7, 2003, and listed the time, place, and nature of the hearing; included a statement of the legal authority and jurisdiction under which the hearing was to be held; referred to particular sections of the statutes and rules involved; and included a short, plain statement of the matters asserted.

11. At the hearing on April 29, 2003, both the Carrier and Provider were represented.

12. The claimant had disc herniations at L3-L4, L4-L5, and L5-S1; spinal stenosis; lateral recess stenosis at L2-S2; bowel and bladder dysfunction; chronic low back pain with lumbar radiculopathy; failed conservative treatment; and areas of fibrosus pseudoarthrosis at S1-S2; and compression to S2.

13. During the surgery, the Provider observed large disc herniations at L3-L4, L4-L5, and L5-S1.

14. The Provider completed the following surgical procedures on the claimant:

- bilateral laminectomy at L2-L3, L3-L4, L4-L5, L5-S1, and S1-S2 with foraminotomies at L2, L3, L4, L5, S1 and S2 bilaterally;
- excision herniated lumbar disc L3-L4, L4-L5, L5-S1;
- sacroiliac graft;
- anterior fusion from posterior approach L3-L4, L4-L5, L5-S1 using 13 X 24 Ray cages;
- exploration of fusion area with excision of fibrosis pseudoarthrosis S1-S2;
- lateral transverse fusion L3-L4, L4-L5, L5-S1, S1-S2;
- EBI bone stimulation of lateral transverse fusion L3-S2; and
- posterolateral posterior facet fusion L3-L4, L4-L5, L5-S1, S1-S2.

15. In addition to the procedures that were specifically preauthorized, the other procedures performed were medically necessary.

16. The CPT codes used in this case have distinctive descriptions for lateral and posterior fusions.

17. Reimbursement for both lateral and posterior levels is appropriate.

18. The Provider did not include a modifier to show the laminectomy was followed by arthrodesis, as required by Surgery Ground Rule I(E)(2)(b).

19. The Surgery Ground Rules describe CPT codes 63048, 22650, 22842, and 20975 as already having a second-procedure reduction calculated into the MAR.

20. To use a modifier for CPT codes 63048, 22650, 22842, and 20975 would be duplicative.

21. MRD and the Provider corrected the amount requested, so that the amounts listed on the chart in Finding of Fact 6 reflects the correct amounts, as if they had included a modifier.

22. There was no evidence of a negative impact caused by the failure to use a modifier.

V. Conclusions of Law

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

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

3. The Carrier had the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h).

4. Because the Carrier preauthorized procedures, other surgical procedures were medically necessary, and incorrect billing has been corrected, the Provider is entitled to reimbursement for the surgical services he performed.

5. The Provider is entitled to reimbursement of $12,291.50.

ORDER

IT IS, THEREFORE, ORDERED that the City of Houston reimburse Eric H. Scheffey, M.D., the amount of $12,291.50 for surgical services performed on February 5, 2002.

Signed August 22, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

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SARAH G. RAMOS
Administrative Law Judge