DOCKET NO. 453-03-2432.M4
MDR Tracking No.: M4-02-3206-01

LONESTAR ORTHOPEDICS, COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitione	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is an appeal from a decision of the Texas Workers' Compensation Commission's Medical Review Division ("MRD") denying the claim of Lonestar Orthopedics ("Petitioner") for $20,000 to reimburse treatment through a two-level intra-discal electro-thermal ("IDET") procedure. The MRD found that payment by Texas Mutual Insurance Co. ("Respondent") of $759.00 for this procedure was fair and reasonable. This opinion agrees with the MRD's decision.

JURISDICTION AND VENUE

The Texas Workers' Compensation Commission ("TWCC" or "Commission") has jurisdiction over this matter pursuant to § 413.031 of the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. ch. 401 *et seq*. The State Office of Administrative Hearings ("SOAH") has jurisdiction over matters related to the hearing in this proceeding, including authority to issue a decision and order, pursuant to § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003. No party challenged jurisdiction or venue.

PROCEDURAL HISTORY

The hearing was convened June 16, 2003, at SOAH facilities in Austin, Texas. Administrative Law Judge ("ALJ") Barbara C. Marquardt presided. Texas Mutual Insurance Company was represented by Orlesia A. Hawkins, and Christopher H. Trickey, attorneys. Petitioner was represented by Dr. Kenneth Berliner, *pro se*. Following adjournment on June 16, the hearing reconvened for one day on June 24, 2003, to allow additional testimony and argument. The record closed on July 1, 2003.

ALJ Mike Rogan subsequently read the entire record of the proceeding and prepared this Proposal for Decision.

BACKGROUND OF THE CASE

The record developed at the hearing revealed that, on ___, the claimant suffered a compensable injury to the back. In an effort to relieve the claimant's chronic pain from that injury, Dr. Kenneth G. Berliner[1] of Lonestar Orthopedics performed a two-level IDET procedure on April

[1]Dr. Berliner is a board-certified orthopedic surgeon.

27, 2001, inserting a catheter into the intervertebral discs at the L4-5 and L5-S1 levels. Petitioner subsequently billed $10,000.00 for each level treated (a total of $20,000.00).

Respondent, the insurer for claimant's employer, agreed to pay only $759.00 for the services at issue, asserting that this rate of reimbursement "has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(b)."[2] After Petitioner sought a review of the insurer's initial determination, Respondent specifically reiterated its rationale for reimbursement in a letter of July 20, 2001, as follows:

> The fair and reasonable reimbursement for IDET is based on the relative value units ["RVU"] for [CPT Code] 62292 since this describes similar work, knowledge, skill, risk to the patient and risk to the physician. The conversion factor of the 4-1-96 surgery section is $101.16. The RVU for 62292 is 5. The product of the conversion factor and RVU is $506.00. Also, reimbursed the second level at the multiple procedure rule $253.00. No additional reimbursement is recommended. [The cited CPT code was derived from TWCC's 1996 *Medical Fee Guideline* ("*MFG*")[3]]

Petitioner then sought TWCC dispute resolution. The MRD issued a decision in the dispute on January 31, 2003, declaring its agreement with Respondent's determination of a proper reimbursement level. According to the MRD, Respondent had satisfied the criteria set out in 28 TEXAS ADMINISTRATIVE CODE ("TAC") § 133.304(I) by submitting a credible methodology for calculating a fair and reasonable reimbursement in this case. At the same time, the MRD concluded, Petitioner had failed to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement," as required by 28 TAC § 133.307. Petitioner made a timely request for SOAH review of the MRD decision.

EVIDENCE AND ARGUMENTS

1. Principal Issue

The *MFG* applicable to the period in which the disputed services occurred does not include a CPT code for the IDET procedure. Consequently, no Commission rules or guidelines explicitly define a maximum allowable reimbursement ("MAR") for these services. However, no party has challenged the medical necessity of the services in this case. Under these circumstances, the insurer and provider must justify their respective determinations of what constitutes fair and reasonable reimbursement" with the provider, as Petitioner, bearing the overall burden of proof.

B. Petitioner's Evidence and Arguments

Petitioner argued that the reimbursement Respondent offered for an IDET procedure in this case is only 89 percent of the amount that Medicare would have provided for such a procedure in 2001. Since, in Petitioner's opinion, even payments at 100 percent of the levels authorized for

[2]Statutory amendment changed § 413.011(b) to § 413.011(d) in the year 2001, with no change in text.

[3]The *MFG* (28 TAC § 134.201) adopted 1994 CPT codes published by the American Medical Association.

Medicare are inadequate to maintain a viable medical practice, reimbursement at any lower rate is, virtually by definition, unfair and unreasonable.

While acknowledging that the $20,000.00 billed for the IDET procedure on April 27, 2001, was "high for a straightforward case," Petitioner contended that its fee structure was properly chosen "to encompass a broad spectrum of case difficulty"; to reflect Dr. Berliner's training, experience, and skill, as well as the risks associated with his medical practice; and to defray the considerable annual expenses incurred to maintain Petitioner's offices and operations.[4]

At the hearing, Dr. Berliner submitted an exhibit summarizing the payments he had received for almost all the other IDET procedures he had performed during 2001. (Records for one patient were unavailable.) In these 38 cases, the average reimbursement for IDET treatment of a single disc was $5,311.79. For the 22 of these cases in which a second disc also received IDET treatment at the same time, the average reimbursement for the second disc was $3,431.91.

Petitioner suggested that the parties might have been able to resolve their dispute in this case by negotiating a compromise level of reimbursement, had not Respondent violated 28 TAC § 133.301(b), which prohibits an insurer from changing a billing code on a medical bill or reimbursing billed services at another billing code value, "unless the insurance carrier contacts the sender of the bill and the sender agrees to the change." In this case, Respondent did not contact Petitioner before determining that it would reimburse the disputed IDET services on the basis of a billing code differing from that initially cited in Petitioner's bill.

Petitioner also criticized the methodology Respondent used to calculate its payments for IDET services. Essentially, Respondent found IDET to be analogous to the procedure described in CPT Code 62292 *i.e.*, "injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels; lumbar." Respondent accordingly reimbursed Petitioner (for treatment of the first disc level billed) at the MAR for this code, as listed in the *MFG i.e.*, $506.00. However, Dr. Berliner testified that IDET is more difficult and time-consuming than the Code 62292 procedure. IDET requires a larger-bore introducer needle, entails the added complexity of threading a catheter through the needle, and creates longer x-ray exposure for the physician.

In addition, Petitioner challenged Respondent's use of the Multiple Procedure Reimbursement Rule[5] to justify reimbursement of IDET treatment for the second disc level in this case at only $253.00 (half the rate of reimbursement for the first disc level). According to Dr. Berliner, his treatment of each of the claimant's two discs on April 27, 2001, should be considered a separate surgical procedure, not subject to reductions in charges under the Multiple Procedure Rule. Dr. Berliner noted that IDET treatment at each level required the repetition of all major steps in the procedure, including a separate needle insertion and catheter placement. Moreover, the treatment of the disc at one level did not meaningfully contribute to or affect the treatment of the disc at the other level.

C. Respondent's Evidence and Arguments

[4]Dr. Berliner submitted in evidence a compilation of such expenses for 2001 that totaled over $954,000.

[5]1996 *MFG* Surgery Ground Rules (I)(D)(1)(b).

Respondent argued that its methodology for determining IDET reimbursement in this case achieves a "fair and reasonable"result, as required by §413.011(d) of the Act and applicable TWCC regulations. The methodology takes into account the relative value of the IDET procedure by comparing it to the most similar procedure that is specifically identified by a CPT code in the *MFG*. Dr. Nick Tsourmas[6], who testified for Respondent, stated that Oratec (the firm that first developed and manufactured IDET equipment) had advised Respondent to use CPT Code 62292 as the code that most closely describes and values the resources required for IDET. Dr. Robert Joyner[7], also a witness for Respondent, agreed that Respondent's methodology is sound because it utilizes standardized techniques to assess the relative value of services in question.

While judging Respondent's methodology to be conceptually valid, Dr. Joyner (who has performed IDET procedures on about 100 discs) noted that he bills his own IDET services at the MAR for a different CPT codeB*i.e.*, 62287Bwhich is $1,315.00. However, the payments he ultimately receives for such services actually average about $500.00. He concluded that the $759.00 paid by Respondent in this case for a two-level IDET procedure was, based on his experience, very reasonable. On the other hand, both he and Dr. Tsourmas found the $10,000.00-per-level fee sought by Petitioner to be grossly disproportionate for what Dr. Joyner characterized as a mere "percutaneous procedure."

Dr. Joyner and Dr. Tsourmas noted that practitioners from a number of specialties-not just surgeons-can be certified to perform IDET after taking a course paid for by Oratec that may last from half a day to two days. (Both of these witnesses, as well as Dr. Berliner, were certified for IDET in this manner.) Dr. Joyner and Dr. Tsourmas charactered IDET, under normal circumstances, as a relatively simple and standardized procedure that takes less than half an hour, performed on an out-patient basis. Certainly, the specific procedure performed by Dr. Berliner in this case fit that paradigm. According to these witnesses, the types of major surgical procedures that IDET is intended to forestall (such as lumbar fusion or laminotomy) present much greater difficulty and demand much greater exertions by the surgeon-a difference, in comparison to IDET, "like night and day." Yet the MAR under the 1996 *MFG* for a laminotomy (CPT Code 63030) is only $3,035.00, less than a third of what Petitioner billed for one level of IDET treatment in this case.

Dr. Joyner also voiced the view that paying $10,000.00 for a relatively minor "ambulatory procedure" such as IDET would probably encourage physicians to do the procedure unnecessarily, thus seriously undermining the objective of achieving "effective medical cost control," as expressed in § 413.011(d) of the Act.

Both Dr. Joyner and Dr. Tsourmas, as well as Respondent's witness Richard Ball (a dispute analyst for the company), expressed the opinion that the *MFG*'s Multiple Procedure Reimbursement Rule should apply in this case, thus halving the appropriate reimbursement for the second of the two IDET procedures Dr. Berliner performed upon the claimant on April 27, 2001. None of the witnesses elaborated on this opinion in significant detail.

ALJ'S DISCUSSION

[6]A board-certified orthopedic surgeon who has practiced in Austin since 1983, Dr. Tsourmas has served on a number of the Commission's advisory committees, including the one that revised the *Spine Treatment Guideline* in 2000.

[7]Dr. Joyner is board-certified in anesthesiology and pain management.

1. Determining Fair and Reasonable Reimbursement

In the ALJ's view, Petitioner emphatically failed to meet its principal burden of proof in this case. Petitioner has provided virtually no meaningful evidence to demonstrate that its charges for IDET services are "fair and reasonable," as defined by pertinent statutory and regulatory criteria.[8]

Perhaps most fundamentally, Petitioner has offered nothing more than Dr. Berliner's broad, subjective opinion to establish that the real value of the service at issue is in any way commensurate with the $10,000.00-per-disc billed by Petitioner. And indeed, the real import of Dr. Berliner's testimony, taken as a whole, seems to be that such a billing is intended by Petitioner as an initial negotiating stance in dealing with insurers or other payers and that some subsequent reduction in the initial billing is typically expected.

In the ALJ's view, Petitioner's position thus ignores the authorities that rather clearly show the TWCC system to be primarily a value-based reimbursement regime. In particular, the adoption preamble for part of the 1996 *MFG* explained that the MAR levels compiled in the regulations were derived from relative value units and conversion factors previously published in other sources.[9] In a preamble for the 2002 *MFG*, the Commission reiterated more emphatically that the Texas system of workers' compensation represented a movement from "Charge-based to Relative Value Fees." The Commission further stated:

> The trend is away from using the providers' charges as a basis for setting the allowed or required payments (*e.g.*, payments calculated as a percentage of billed charges). The Commission has previously rejected such charge-based systems because they "leave ultimate reimbursement in the control of the [provider], thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living." [Citing 1997 Hospital Fee Guideline preamble.][10]

Much of Petitioner's evidence focuses upon its cumulative annual operating costs, with one compilation reflecting such costs of almost $1 million. Clearly, however, the TWCC system is not, in any direct sense, a cost-based system. As noted in a 1997 rules preamble, "The Commission chose not to adopt a cost-based reimbursement methodology. . .. The cost-based methodology is . . . questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for a similar treatment to an injured individual of

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[8]The pertinent criteria are set out most fundamentally in § 413.011(d) of the Act, which states:

> Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or someone acting on that individual□s behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

[9]21 *TexReg* 2362.

[10]27 *TexReg* 12337.

an equivalent standard of living contained in Texas Labor Code § 413.011."[11]

The ALJ agrees that analysis of a provider's costs might be relevant to some degree in a systematic examination of whether specific reimbursement levels contribute to the statutory objective of "ensuring the quality of medical care" (a criterion included in § 413.011). However, the evidence presented in this case certainly does not provide a sufficiently coherent context to determine how Petitioner's billings for IDET services relate to that general issue. In any case, the ALJ is doubtful that Petitioner could present any convincing rationale for its attempt to defray a full 2 percent of its enumerated annual costs ($20,000.00 out of $1 million) with a single one-hour procedure.

Petitioner's effort to call into question the rationale for Respondent's specific level of reimbursement in this case was perhaps somewhat more credible. Dr. Berliner did demonstrate that an IDET procedure is somewhat more involved than the typical procedure classified under CPT Code 62292. However, he did not precisely characterize the differences in these procedures or quantify the value associated with such differences. Given the state of the record, the ALJ cannot determine that Dr. Berliner effectively rebutted the testimony of Dr. Tsourmas and Dr. Joyner, on behalf of Respondent, that such differences are of marginal significance in setting the reasonable value of the respective procedures.

By conceptually tying its level of reimbursement for IDET to an approved MAR under the *MFG*, Respondent has adopted a methodology that is presumptively in accord with the Act and implementing regulations. Respondent's development, documentation, and explanation of the methodology appears to be consistent with 28 TAC § 133.304(I), as the MRD concluded in earlier proceedings. Petitioner simply has not met its burden of proof-either to demonstrate that Respondent's methodology does not define a fair and reasonable level of reimbursement in this case or to demonstrate that its own methodology does.

2. Alleged Violation of Rule 133.301(b)

While the ALJ questions whether a violation of 28 TAC 133.301(b) would have any direct bearing upon assessing the propriety of a particular reimbursement, Respondent does not appear to have violated that rule in this case. The CPT code noted in Petitioner's billing (22899) is not a substantive billing code that identifies a particular procedure or a specific amount of appropriate reimbursement. Rather, it simply indicates that *no* specific code or MAR applies to the procedure in question.

Similarly, Respondent did not substitute a different code for 22899 in documenting its reimbursement in this case. It merely made reference to the specific Code 62292, analogizing that procedure to the unlisted IDET procedure in order to develop a rationale for reimbursement. Although Respondent offered Petitioner reimbursement *equal* to that associated with Code 62292, it did not actually make that reimbursement *under* Code 62292. Indeed, Respondent clearly indicated that it was reimbursing a service for which no specific code existed; that is, it acknowledged, at least by implication, that it was acting under Code 22899, although it disagreed in this instance with Petitioner as to the appropriate payment for services in this category.

3. Application of Multiple Procedure Rule

[11] 22 *TexReg.* 6276.

The MRD determined that reimbursement for the second of the two IDET procedures performed by Dr. Berliner in this case should be halved, in accordance with the Multiple Procedure Reimbursement Rule, although the MRD enunciated no specific rationale for this determination.

The rule is not a model of clarity or precision. However, Subsection (1)(b) appears to list all of the circumstances in which "secondary or subsequent procedures" care to be reimbursed at 50 percent of the otherwise applicable rate. The only listed circumstance that logically might apply in this case is Subsection (1)(b)(ii): "the secondary or subsequent procedures are not performed through the same incision but are related to the primary procedure."

The two IDET procedures performed in this case were certainly "related" in some way-they were almost identical and were performed on adjacent vertebral discs during a span of about 39 minutes. But are such general relationships sufficient to trigger the reimbursement reductions under the rule? Dr. Berliner logically argued that he had to repeat most of the basic elements of the IDET procedure in treating each disc. On the other hand, the record contains no real evidence by which to gauge the relative significance of those other activities and resources that must have been common to both procedures-for example, anesthetizing the patient, preparing her for treatment and monitoring her condition afterward, and even the overall logistics of scheduling the necessary facility and the physician's time.

Under these circumstances, the ALJ concludes that Petitioner has not discharged its burden of proof to demonstrate that the MRD incorrectly applied the Multiple Procedure Reimbursement Rule in this case.

CONCLUSION

Petitioner has not met its burden to prove by a preponderance of the evidence either 1) that Petitioner's charges for the IDET services in dispute were fair and reasonable or 2) that Respondent's actual level of reimbursement for such services was *not* fair and reasonable. Accordingly, the relief sought by Petitioner must be denied, as previously determined by the Commission's MRD in a decision dated January 31, 2003.

FINDINGS OF FACT

1. The Claimant suffered an injury to the back on ___. In an effort to relieve Claimant's chronic pain from the injury, Dr. Kenneth G. Berliner of Lonestar Orthopedics ("Petitioner"), on April 27, 2001, performed a two-level intra-discal electro-thermal ("IDET") procedure upon the L4-5 and L5-S1 discs.

2. Petitioner billed the procedures noted in Finding of Fact No. 1 at $10,000.00 per level treated (a total of $20,000.00).

3. Texas Mutual Insurance Co. ("Respondent"), the insurer for Claimant's employer, reimbursed Petitioner only $759.00 for the IDET procedures, on the basis that this amount represented the "fair and reasonable" reimbursement for such services ($506.00 for the first procedure and $253.00 for the second).

4. Petitioner subsequently sought medical dispute resolution before the Texas Workers' Compensation Commission ("Commission").

5. On January 31, 2003, the Commission's Medical Review Division ("MRD") issued a decision confirming that Respondent's reimbursement in this case was fair and reasonable, because based upon a credible methodology, and finding that Petitioner had failed to justify its billing for the disputed services.

6. Petitioner made a timely request for review of the MRD decision before the State Office of Administrative Hearings ("SOAH").

7. After proper notice, a hearing in this action was convened before SOAH on June 16, 2003. The hearing reconvened for a second day on June 24, 2003. The record in the case closed on July 1, 2003.

8. The Commission's *Medical Fee Guideline* ("*MFG"*), 28 TEX. ADMINISTRATIVE CODE ("TAC") § 134.201, does not include a specific CPT code for the IDET procedure, and accordingly, no Commission rules or guidelines define a maximum allowable reimbursement ("MAR) for these services.

9. Respondent's methodology for setting its level of reimbursement was based upon identifying a CPT code that described procedures entailing work, knowledge, skill, and risk similar to those entailed in IDET procedures. Respondent concluded that CPT Code 62292-injection procedures for chemonucleolysis, including discography"- satisfied these criteria.

10. Based upon its finding that the procedures are analogous, Respondent reimbursed the first IDET procedure performed upon Claimant at the MAR level for CPT Code 62292.

11. Based upon the *MFG*'s Multiple Procedure Reimbursement RuleB*i.e.*, Surgery Ground Rules (I)(D)(1)(b)- Respondent reimbursed the second IDET procedure performed upon Claimant at 50 percent of the amount for the first procedure.

12. The two IDET procedures at issue were performed upon adjacent discs, inches apart, within a period of approximately 39 minutes.

13. While differences exist between them, both IDET and CPT Code 62292 procedures are percutaneous insertions into the intervertebral disc, monitored by moving-picture x-rays, requiring essentially similar skill, work, and risk.

14. Petitioner identified no specific basis for its billing in this case, other than general rationales that Dr. Berliner is very skilled in IDET procedures and that Petitioner's operations incur large annual expenses.

CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented pursuant to the Texas Workers' Compensation Act ("the Act"), TEX. LABOR CODE ANN. § 413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the

hearing in this proceeding, including the authority to issue a final decision and order, pursuant to §§ 402.073(b) and 413.031(k) of the Act and TEX. GOV'T CODE ANN., Ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TAC § 133.305(g) and §§148.001-148.028.

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

5. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC §148.21(h).

6. Based upon the foregoing Findings of Fact, Respondent appropriately applied the MAR for Code 62292 to define the basic level of "fair and reasonable" reimbursement for an IDET procedure in this case, in accordance with § 413.011(d) of the Act and 28 TAC §133.304(I).

7. Based upon Findings of Fact Nos. 11 and 12, Respondent properly reimbursed Petitioner for the second IDET procedure in controversy at 50 percent of the rate for the first procedure, in accordance with the *MFG*, Surgery Ground Rules (I)(D)(1)(b)(ii).

8. Based upon the foregoing Findings of Fact and Conclusions of Law (and consistent with the prior decision of the Commission's MRD), Petitioner's request for additional reimbursement is unsupported and should not be approved.

ORDER

IT IS, THEREFORE, ORDERED that Lonestar Orthopedic's request for additional reimbursement for a two-level IDET procedure is denied.

SIGNED this 27th day of August, 2003.

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF
ADMINISTRATIVE HEARINGS