

**SOAH DOCKET NO. 453-03-4232.M4  
MDR TRACKING NUMBER M4-03-0625-01**

**MARIO O. KAPUSTA, M.D.,  
Petitioner**

v.

**LIBERTY MUTUAL INSURANCE  
CORPORATION,  
Respondent**

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**BEFORE THE STATE OFFICE**

**OF**

**ADMINISTRATIVE HEARINGS**

**DECISION AND ORDER**

On two separate grounds, Petitioner Mario O. Kapusta, M.D. (Provider) appealed the Findings and Decision of the Texas Workers' Compensation Commission's Medical Review Division (MRD) denying additional reimbursement for services provided in conjunction with an anterior arthrodesis procedure.<sup>1</sup> First, Provider billed the primary procedure as vascular surgery (CPT Code 37799) and added modifier -62, which is used when two surgeons with different skills are required to manage a surgical procedure. Liberty Mutual Insurance Corporation (Carrier) denied payment reasoning Dr. Kapusta's procedure was incidental to the primary procedure and did not warrant separate reimbursement. The MRD found that Provider failed to submit documentation supporting a need for a change in the amount of reimbursement. The Administrative Law Judge (ALJ) finds that Provider is not entitled to additional reimbursement on this point.

Second, Provider billed for vascular surgery (CPT Code 37799) and added modifier -51 (two units) for each level of the spine exposed for the orthopaedic surgeon. The Carrier denied payment on the ground that the second level of exposure was included in the primary procedure. The MRD found that Provider did not specify what procedures during the operative session required separate billing codes and did not recommend reimbursement. The ALJ finds that Provider is entitled to the additional reimbursement of \$637.00 for this issue.

**I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION**

On January 5, 2004, ALJ Tommy Broyles convened the hearing at the William P. Clements Building, 300 West 15<sup>th</sup> Street, Austin, Texas. Petitioner appeared *pro se*. Attorney Charlotte Salter represented the Carrier. Notice and jurisdiction were not contested and will be addressed in the Findings of Fact and Conclusions of Law. The record closed on the same day at the conclusion of the hearing.

**II. EVIDENCE AND BASIS FOR DECISION**

The issues in this case involve reimbursement for surgical services provided as part of an anterior arthrodesis procedure performed on April 3, 2002. The facts are not in dispute. Claimant's

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<sup>1</sup> This is a spinal fusion performed from the front of the patient.

fusion required an anterior approach to the L3-L4 and L5-S1 levels. Provider provided surgical opening and closing; moved internal organs, veins, and arteries to afford the orthopaedic surgeon access to the spine; and remained nearby in the event a vein or artery was nicked or some other complication arose. Provider billed the procedure under CPT Code 37799 (unlisted procedure, vascular surgery) and added modifier -62, which means the surgery required two surgeons with different skills. Provider argues that he is a second surgeon, performing vascular surgery, and may not perform orthopaedic surgery nor bill under its codes.

The Carrier reduced reimbursement arguing that anterior arthrodesis should have been billed under CPT Code 22558 (anterior approach for lumbar fusion) with modifier -65. This modifier is used when co-surgeons perform separate procedures through the same incision. Under this modifier, each surgeon is entitled to receive only 75% of MAR for each primary surgical procedure.

After reviewing the Medical Fee Guidelines, the ALJ determined that they specifically mandate the use of a co-surgeon modifier when one surgeon prepares the approach and another performs the spinal fusion. Surgery Ground Rule I.E.2.d states:

When anterior arthrodesis approach is performed by a different surgeon, both surgeons bill using the anterior arthrodesis CPT code with modifier -65.

It should be noted that the ALJ is aware of the decision cited by Provider, SOAH Docket No. 453-01-1460.M5.<sup>2</sup> However, it appears that the parties in that proceeding failed to bring the ground rule to the ALJ's attention. In any event, it was not relied upon in that case and the ALJ finds it dispositive here. The evidence in our case suggest that the approach, performed by the vascular surgeon, and the arthrodesis, performed by the orthopaedic surgeon, are not separate procedures. In fact, orthopaedic surgeons may perform both. Accordingly, when two surgeons perform the surgery, the MFG allows recovery of only 75% of the MAR for each surgeon. The orthopaedic surgeon in this case, Dr. Cotler, appropriately billed pursuant to the MFG using CPT 22558 -65. Provider failed to do the same. Thus, no additional reimbursement is awarded Provider.

The second issue concerns Provider's exposure of two levels of the spine for the orthopaedic surgeon. The Carrier only paid for one level of exposure. According to the MFG, each interspace in addition to the initial level arthrodesis should be billed using CPT Code 22585 and reimbursed at the MAR of \$637.00. Provider exposed one level in addition to the single level for fusion; thus, additional reimbursement of \$637.00 is awarded.

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<sup>2</sup>Employers Insurance Of Wausau v. Texas Workers' Compensation Commission, Medical Review Division and Mario Kapusta, M.D.; SOAH Docket No. 453-01-1460.M5.

### III. FINDINGS OF FACT

1. A workers' compensation claimant suffered a compensable injury under the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq.*, on \_\_\_\_, when his employer had workers' compensation coverage with the Liberty Mutual Insurance Corporation (Carrier).
2. The claimant's subsequent treatment included a lumbar fusion (arthrodesis) at the L3-L4 and L5-S1 spinal levels.
3. Because the Claimant's surgery required an anterior approach to reach the spine, Dr. Mario O. Kapusta, M.D. (Provider), a vascular surgeon, provided surgical opening and closing.
4. Provider billed the Carrier using CPT Code 37799-62 (unlisted procedure, vascular surgery; second surgeon required) for the primary surgery.
5. Provider exposed two spinal levels for the orthopaedic surgeon and billed the Carrier using CPT Code 37799-51 (unlisted procedure, vascular surgery, multiple procedures) for each of the two levels of the spine exposed.
6. The 1996 Medical Fee Guidelines (MFG) adopts the American Medical Association Current Procedure Terminology (CPT) codes, and sets the maximum allowable reimbursement (MAR) for many medical procedures.
7. CPT Code 22558 is assigned for anterior approach for lumbar fusion, which was the primary surgical procedure performed.
8. CPT Code 22558 has a MAR of \$2,660.00.
9. CPT Code 22585 is assigned for the second spinal level exposed.
10. CPT Code 22585 has a MAR of \$637.00.
11. Under the MFG, the -65 modifier signifies "co-surgeons," which means that each surgeon performs a separate procedure through the same incision, and each is reimbursed 75% of the MAR for each primary surgical procedure.
12. Guideline Surgery Ground Rule I.E.2.d. provides that when an anterior arthrodesis approach is performed by a surgeon other than the orthopaedic surgeon, both surgeons are to bill for the procedure using the anterior arthrodesis CPT code with modifier -65.
13. Provider submitted a bill to the Carrier for \$15,500.00, which was reduced to \$1,995.00 and paid.

14. The amount paid by the Carrier is 75% of the MAR for CPT Code 22558-65.
15. Provider exposed an interspace in addition to single level arthrodesis and was not reimbursed by the Carrier for CPT Code 22585.
16. Provider made a timely request to the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the disputed reimbursement.
17. The MRD did not recommend additional reimbursement.
18. On July 11, 2003, Provider requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.
19. The Commission mailed notice of the hearing's setting to the parties at their addresses on August 12, 2003.
20. The notice included the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.
21. At the hearing on January 5, 2004, Provider appeared *pro se*, and attorney Charlotte Salter, represented the Carrier.

#### **IV. CONCLUSIONS OF LAW**

1. The Commission has jurisdiction to decide the issues presented pursuant to §413.031 of the Act.
2. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(k) of the Act 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. Provider, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).
5. Provider properly effected an appeal of the MRD decision to SOAH.

6. The MFG applies to the services delivered in this case.
7. When an anterior arthrodesis approach is performed by a different surgeon, both surgeons are to bill using the anterior arthrodesis CPT Code (in this case, 22558) with the co-surgeon modifier -65, pursuant to Surgery Ground Rule I.E.2.d. in the MFG.
8. Based on Surgery Ground Rule I.E.2.d. in the MFG, Provider is entitled to 75% of the MAR for the anterior approach for lumbar fusion with co-surgeons utilizing the same incision (CPT Code 22558) that was performed on Claimant on April 3, 2002.
9. Based on the above Findings of Fact and Conclusions of Law, additional reimbursement is not required for the primary procedure.
10. Based on the MFG, Provider is entitled to reimbursement at the MAR amount for each level in addition to a single anthrodesis procedure.
11. Based on the above Findings of Fact and Conclusions of Law, the Carrier should reimburse Provider \$637.00

### **ORDER**

IT IS, THEREFORE, ORDERED that Mutual Liberty Insurance Corporation reimburse Mario O. Kapusta, M.D., for fees incurred in treating the Claimant in the amount of \$637.00.

**SIGNED March 6, 2003.**

**TOMMY BROYLES  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS**