DOCKET NO. 453-03-4249.M4
TWCC NO. M4-03-0643-01

PHILLIP REESE ADAMS, M.D.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
TPCIGA FOR RELIANCE NATIONAL	§	
INDEMNITY COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Petitioner Phillip Reese Adams, M.D. (Provider) appealed the Findings and Decision of the Texas Workers' Compensation Commission's Medical Review Division (MRD) denying additional reimbursement for vascular surgery services provided in conjunction with an anterior arthrodesis procedure.[1] The Provider billed the primary procedure as vascular surgery (CPT Code 37799) and added modifier -62, which is used when two surgeons are required to manage a specific surgical procedure. Reliance National Indemnity Company (Carrier), an impaired carrier whose obligations are being discharged by TPCIGA,[2] reduced the charge to a fair and reasonable amount. The MRD found that the Provider failed to submit documentation to support a need for a change in the amount of reimbursement. The Administrative Law Judge (ALJ) finds that the Provider is not entitled to reimbursement as a second surgeon who performed a specific surgical procedure because the opening and closing for an anterior arthrodesis is not a separate procedure. Specifically, the 1996 Medical Fee Guideline's Surgery Ground Rule I.E.2.d. provides that when different surgeons perform an anterior arthrodesis procedure, modifier -65 should be used, and each surgeon is entitled to 75% of the maximum allowable reimbursement (MAR). Additional reimbursement is not ordered for this procedure.

Additionally, the Provider billed for vascular surgery (CPT Code 37799) and added modifier 52 (reduced services) for each level of the spine exposed for the orthopaedic surgeon. The Carrier denied payment on the ground that this procedure was included in another procedure on the same date. The MRD found that the Provider did not specify what procedures during the operative session required separate billing codes and did not recommend reimbursement. CPT Code 22585 in the 1996 Medical Fee Guideline provides that each additional interspace exposed during an anterior arthrodesis shall be reimbursed at a MAR of $637.00. This decision recommends reimbursement of that amount.

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[1] This is a fusion performed from the front of the patient.

[2] TPCIGA is the acronym for Texas Property and Casualty Insurance Guaranty Association, which was statutorily created to discharge the obligations and responsibilities of impaired carriers. TEX. INS. CODE ANN. art. 2128-c.

I. PROCEDURAL HISTORY, NOTICE AND JURISDICTION

On October 7, 2003, ALJ Michael J. Borkland convened the hearing at the William P. Clements Building, 300 West 15th Street, Austin, Texas. Petitioner appeared *pro se*. Attorney Steve Tipton 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

At issue in this case is reimbursement for vascular surgical services provided as part of an anterior arthrodesis procedure performed on January 14, 2002. The facts are not in dispute. Claimant's fusion required an anterior approach to the L3-L4 and L5-S1 levels. The 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. The Provider billed the procedure under CPT Code 37799 (unlisted procedure, vascular surgery) and added modifier -62, which means two surgeons were required. The Carrier reduced reimbursement to a fair and reasonable amount and argued that anterior anthrodesis should have been bill under CPT Code 22558 (anterior approach for lumbar fusion) with modifier -65.[3] Additionally, the Provider billed for each level of the spine exposed for the orthopaedic surgeon under CPT Code 37799-52 (unlisted procedure, vascular surgery, reduced services). The Carrier stated that these procedures were included in the primary procedure and did not pay any of the requested amount.

The first issue was previously addressed in SOAH Docket Nos. 453-01-1460.M5 (first decision) and 453-02-2257.M4 (second decision), with different results. The facts in the two cases are similar to the undisputed facts presented here. In the first decision, the surgeon billed using CPT Code 37799-51 (unlisted procedure, vascular surgery, multiple procedures). The insurance carrier argued that reimbursement should have been made using CPT Code 22558-62 (arthrodesis, anterior interbody technique; lumbar with bone graft). The ALJ found that the surgeon appropriately billed using CPT Code 37791 and added modifier -62 because the procedure required unique skill and responsibility on the part of the vascular surgeon, which was unrelated to the orthopaedic surgery. The ALJ did not address Surgical Ground Rule I.E.2.d.

In the second decision, the same surgeon billed using CPT Code 37799-62 (vascular surgery requiring two surgeons). The ALJ determined that the ground rule cited above required use of the -65 modifier and ordered that the surgeon should be reimbursed at 75% of the MAR for the primary

[3] The 1996 Medical Fee Guideline provides that modifier -65 should be used when co-surgeons perform separate procedures through the same incision and each should be reimbursed at 75% of the MAR for each primary surgical procedure. Surgical ground rule I.E.2.d. provides that "when anterior arthrodesis approach is performed by a different surgeon, both surgeons bill using the anterior arthrodesis CPT code with modifier -65."

surgical procedure (CPT Code 63090), which was the CPT Code for vertebral carpectomy performed by the orthopaedic surgeon. [4]

The Carrier submitted several pages from the American Medical Association's CPT 2003 publication. (Exh. R. 1) CPT Code 22558 is the procedure code for an anterior approach for lumbar fusion. Additionally, the 1996 Medical Fee Guideline also codes anterior approach for lumbar fusion with CPT Code 22558.

Surgery Ground Rule I.E.2.d. was properly applied in the second decision and it is proper to similarly apply the rule in this decision.[5] Thus, the ALJ concludes that the Provider should have billed using CPT Code 22558 with the -65 modifier (anterior approach for lumbar fusion with co-surgeons utilizing the same incision). The Carrier has already paid the Provider 75% of the MAR for CPT Code 22558 as a co-surgeon. Thus, no additional reimbursement is ordered.

The second issue concerns exposure of two levels of the spine for the orthopaedic surgeon. The Provider billed $1,500.00 for each level using CPT Code 37799-52. According to the CPT 2003 publication and the 1996 Medical Fee Guideline, each interspace in addition to single level arthrodesis should be billed using CPT Code 22585 and be reimbursed at the MAR of $637.00. The Provider exposed one level in addition to the single level for fusion, thus, additional reimbursement of $637.00 is recommended.

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 Reliance National Indemnity Company (Carrier).

2. The Carrier is impaired and its obligations are being discharged by the Texas Property and Casualty Insurance Guaranty Association.

3. The claimant's subsequent treatment included a lumbar fusion (arthrodesis) at the L3-L4 and the L5-S1 spinal levels.

4. Because the Claimant's surgery required an anterior approach to reach the spine, Paul Reese Adams, M.D. (Provider), a vascular surgeon, 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.

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[4] CPT Code 63090 includes vertebral carpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment.

[5] The Provider argued that the first decision supports his request for reimbursement. The Provider is correct that the first decision does support his request for reimbursement; however, the ALJ disagrees with the decision because Surgery Ground Rule I.E.2.d. was not addressed and it is clearly applicable to the facts of this case.

5. The Provider billed the Carrier using CPT Code 37799-62 (unlisted procedure, vascular surgery; second surgeon required) for the primary surgery.

6. The Provider exposed two spinal levels for the orthopaedic surgeon and billed the Carrier using CPT Code 37799-52 (unlisted procedure, vascular surgery, reduced services) for each of the two levels of the spine exposed.

7. The Guideline adopts the American Medical Association Current Procedure Terminology (CPT) codes, and sets the maximum allowable reimbursement (MAR) for many medical procedures.

8. CPT Code 22558 is assigned for anterior approach for lumbar fusion, which was the primary surgical procedure to expose one level of the spine.

9. CPT Code 22558 has a MAR of $2,660.00.

10. CPT Code 22585 is assigned for the additional spinal level referred to in Finding of Fact No. 6.

11. CPT Code 22585 has a MAR of $637.00 for each additional level exposed.

12. Under the Guideline, 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.

13. 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.

14. The Provider submitted a bill to the Carrier for $11,500.00, which was reduced to $1,995.00 and paid.

15. The amount paid by the Carrier is 75% of the MAR for CPT Code 22558-65.

16. The Provider exposed an interspace in addition to single level arthrodesis and was not reimbursed by the Carrier for CPT Code 22585.

17. The 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.

18. The MRD did not recommend additional reimbursement.

19. On July 11, 2003, the Provider requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

20. The Commission mailed notice of the hearing's setting to the parties at their addresses on August 12, 2003.

21. 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.

22. At the hearing on October 7, 2003, the Provider appeared *pro se*, and attorney Steve Tipton 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. The Provider, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

5. The Provider properly effected an appeal of the MRD decision to SOAH.

6. The Commission's 1996 Medical Fee Guideline (Guideline) 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 Commission's Guideline.

8. Based on Surgery Ground Rule I.E.2.d. in the 1996 Guideline, the 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 January 14, 2002.

9. Based on Findings of Fact Nos. 14 and 15 and Conclusion of Law No. 8, additional reimbursement is not required for the primary procedure.

10. Based on the 1996 Guideline, the Provider is entitled to reimbursement at the MAR amount for each level in addition to a single anthrodesis procedure.

11. Based on Findings of Fact Nos. 6, 10, 11 and 16 and Conclusion of Law No. 10, the Carrier should reimburse the Provider $637.00

ORDER

IT IS, THEREFORE, ORDERED that TPCIGA for Reliance National Indemnity Company reimburse Phillip Reese Adams, M.D., for fees incurred in treating the Claimant in the amount of $637.00.

ISSUED November 12, 2003.

MICHAEL J. BORKLAND
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS