SOAH DOCKET NO. 453-04-1515.M5
TWCC MDR NO. M5-03-1860-01

EAST HARRIS COUNTY ORTHOPEDIC ASSOCIATES, P.A., Petitioner	'	BEFORE THE STATE OFFICE
VS.	'	OF
CONTINENTAL CASUALTY INSURANCE, Respondent	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

East Harris County Orthopedic Associates, P.A. (Provider) appealed the findings and decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD), which denied additional reimbursement for spinal surgery that was performed on (Claimant). The Administrative Law Judge (ALJ) finds Provider is not entitled to additional reimbursement of $13,295 from Continental Casualty Insurance (Carrier) for the spinal surgery performed on Claimant, because the additional procedures were neither pre-authorized nor medically necessary.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Notice and jurisdiction were not contested. Those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened on September 14, 2004, at the State Office of Administrative Hearings (SOAH) before ALJ Sharon Cloninger. Provider was represented by Susan Towne, account manager for Provider through Indevour Business Services, L.P. Carrier was represented by James Loughlin, attorney.

II. DISCUSSION

A. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. Specifically, TEX. LAB. CODE ANN. ' 408.021 provides in pertinent part:

> (a) 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:
>
> (1) cures or relieves the effects naturally resulting from the compensable injury;
> (2) promotes recovery; or
> (3) enhances the ability of the employee to return to or retain employment.

B. Background

Claimant sustained a compensable back injury on ____, and has since undergone eight spinal surgeries while in the care of Eric Scheffey, M.D., and Floyd Hardimon, M.D., both associated with Provider. Additional reimbursement for the eighth spinal surgery is in dispute in this matter.

After Claimant's seventh surgery, Provider requested pre-authorization to perform a lumbar laminectomy,[1] fusion, and instrumentation at the L1-2 level of Claimant's spine. Claimant's pre-operative diagnosis included herniated lumbar disk, L1-L2; pseudarthrosis,[2] L2-L3, L3-L4, L4-L5, L5-S1, S1-S2; hardware loosening; cage loosening; chronic low back pain with lumbar

[1] A laminectomy is the surgical removal of a posterior arch of a vertebrae. Merriam Webster's Medical Dictionary (1995), at 359-360.

[2] Pseudarthrosis is an abnormal union formed by fibrous tissue between parts of a bone that has fractured, usually spontaneously due to congenital weakness. *Id.* at 565.

radiculopathy;[3] disk space narrowing, L1-L2, with retrolisthesis; failed conservative treatment; and post laminectomy syndrome.

On October 1, 2002, Carrier pre-authorized procedures that fall under CPT codes 63047, 22630, and 22842. On that same date, Dr. Scheffey, assisted by Dr. Hardimon, performed spinal surgery on Claimant. The surgical procedure included bilateral laminectomy at T12-L1, L1-L2, L2-L3, L3-L4, L4-L5, L5-S1, S1-S2, with foraminotomies at T12, L1, L2, L3, L4, L5, S1 and S2 bilaterally; excision of herniated lumbar disk, L1-L2; and removal of EBI and electrodes.

Provider then billed Carrier for one of the three pre-authorized procedures, and for 10 additional procedures. Carrier reimbursed Provider $4,687 for the one pre-authorized procedure and two of the 10 additional procedures, but denied reimbursement for the remaining eight procedures, based on a peer review finding that the disputed services were not medically necessary.[4]

C. Evidence

Provider proffered one exhibit, which was admitted, and called no witnesses. Carrier proffered eight exhibits, six of which were admitted, and the testimony of Nicholas Tsourmas, M.D. Offers of proof were accepted on Carrier's remaining two exhibits.

[3] Radiculopathy is any pathological condition of the nerve roots. *Id.* at 581.

[4] Carrier reimbursed Provider $2,583 of $5,983 billed for CPT Code 22842, which was pre-authorized. Carrier also paid $832 of $1,300 billed for CPT Code 22852 and $455 of $500 billed for CPT Code 20975, procedures which were not pre-authorized. Provider did not bill for CPT codes 63047 and 22630, procedures which were pre-authorized, so those services, if rendered, are not in dispute in this proceeding.

1. Parties' arguments

Provider argued that Dr. Scheffey obtained pre-authorization for the disputed services, performed the pre-authorized surgery, and requested reimbursement, which was retrospectively denied in violation of 28 TEX. ADMIN. CODE § 133.301. Carrier argued that the disputed services were neither pre-authorized nor medically necessary, so reimbursement is not warranted.

2. Testimony of Nicholas Tsourmas, M.D.

Nicholas Tsourmas, M.D., an orthopedic surgeon, explained that each CPT code represents a specific and discreet procedure, and that Claimant's eighth operation differed from the pre-authorized procedures in its extent, duration, and repetitive nature.[5] He said Claimant has a "failed surgical spine," and that prior to the eighth surgery, there was objective evidence that fusion one level above the previous surgeries could help Claimant. He said the pre-authorized procedures were at a new level of Claimant's spine.

Dr. Tsourmas explained that the three procedures reimbursed by Carrier were within the scope of the pre-authorized surgery, but that the remaining eight procedures were impossible for Dr. Scheffey to have performed, because the physical structures had already been removed in the 1998 and 2000 surgeries. He said there is no pathology report in the record indicating that any human tissue was removed, although hardware and perhaps scar tissue were removed.

[5] Dr. Tsourmas testified that the identical procedures that Provider is disputing were performed by Dr. Hardimon twice in 1998 and once in 2000.

III. ANALYSIS AND CONCLUSION

Although Carrier pre-authorized surgical procedures for Claimant under three CPT codes, Provider billed for only one of the pre-authorized CPT codes. Carrier reimbursed Provider for that pre-authorized procedure, as well as for two of 10 additional procedures that were not pre-authorized. Because the remaining eight disputed procedures were not pre-authorized, Provider is not entitled to reimbursement for them unless they were medically necessary to treat Claimant's compensable injury, pursuant to TEX. LAB. CODE ANN. § 408.021.

In this proceeding, Provider did not present sufficient evidence to prove the medical necessity of the disputed procedures. In addition, although Carrier did not have the burden of proof, Carrier presented convincing evidence through its witness Dr. Tsourmas that the disputed services were not medically necessary. The ALJ therefore concludes that the disputed procedures were neither pre-authorized nor medically necessary, and that Provider is not entitled to any additional reimbursement from Carrier.[6]

IV. FINDINGS OF FACT

1. Claimant ____ sustained a compensable back injury on ____.

2. Prior to the October 1, 2002 surgery at issue in this case, East Harris County Orthopedic Associates, P.A. (Provider) performed the following seven spinal surgeries on Claimant:

   $ On February 17, 1992, Claimant underwent a decompressive laminectomy at L4-5 and L5-S1 on the left, with L4-5 discectomy and foraminotomy;

[6] During the hearing, Carrier's discovery requests and Provider=s responses were admitted as Carrier Exhibits 7 and 8. The requests were served March 22, 2004, and responses were due April 12, 2004. Responses were not served until April 16, 2004. Based on the untimely responses, Carrier asked that the requests for admission be automatically deemed admitted, specifically referring to the admission regarding medical necessity. The ALJ took the request under advisement. Because the ALJ finds Provider did not prevail on the issue of medical necessity, and that additional reimbursement should be denied, the issue of admitting the responses is moot, so the ALJ will not rule on Carrier's request.

- $ On April 12, 1995, he underwent a decompressive laminectomy at L4-5 and L5-S1, with resection of the L-5 disc, and spinal fusion at L4-5 and L5-S1 with instrumentation from L-4 to S-1;
- $ In March 1997, he underwent surgery for loosening and removal of hardware;
- $ In February 1998, he was taken to the operating room for bilateral laminectomy and foraminotomy at L-1 to S-1, right and left iliac bone graft, exploration fusion mass, excision of pseudarthrosis at L4-5 and L5-S1, anterior fusion through a posterior approach at L-2 to S-1 using Ray cages, lateral transverse fusions at L-2 to S-1 with quarter-inch rods, pedicle screws at L-2 to S-1 with rods and double cross-links and L2-3, L4-5, and fat grafting L-1 to S-1.
- $ In December 1998, he underwent an operation which consisted of removing a bone stimulator and electrodes, excision of lumbosacral cyst, removal of hardware, exploration of fusion mass, resection of pseudarthrosis, bone grafting and pedicle screw holes at L-2 to S-1, sacral grafting, bilateral laminectomy and foraminotomy with partial excision of spinous process, L-1 to S-1, anterior from posterior approach augmentation at L-2 to S-1, lateral transverse fusion at L-2 to S-1, posterolateral facet fusion at L-2 to S-1, fat grafting at L1-2, bilateral lateral instrumentation at L-2 to S-1, with quarter-inch rods and double cross-links at L2-3, L5-S1, using Synthes instrumentation.
- $ In October 1999, he underwent an operation for removal of hardware, exploration of fusion, excision of pseudarthrosis, sacral grafting, bone grafting, pedicle screw holes, L-1 to S-1, anterior fusion from posterior approach, L2-3 posterolateral transverse fusion, L-2 to S-1, with EBI bone stimulator for lateral transverse fusion mass, posterolateral facet fusion at L-2 to S-1, partial excision of spinous process, L-1 to S-1, bilateral laminectomy L-1 to S-1, with foraminotomies, bilateral lateral instrumentation at L-3 to S-1 with quarter-inch rods and single cross-link, and EBI for bilateral transverse fusion mass, fat grafting at L-1 to S-1.
- $ On January 13, 2000, he underwent an operation consisting of I & D of sacral wound, exploration of fusion, excision of pseudarthrosis and debris, curetting of bone and architecture at L-1 to S-1, with decompression of L-1 to S-1 roots, lateral transverse fusion at L-2 to S-1, with graft on at L-2 to S-1 bilaterally. The patient had a muscle flap for secondary closure of dead space, fat grafting at L-1 to S-1, creation of skin and subcutaneous flap for tissue transfer for secondary closure of lumbosacral spine pre- and post-cultures, and copious irrigation with antibiotic solution.

3. Following the January 2000 surgery, Claimant had persistent symptoms, and Provider requested pre-authorization from Continental Casualty Insurance (Carrier) to perform a lumbar laminectomy, fusion, and instrumentation at the L1-2 level of Claimant's spine.

4. On October 1, 2002, Carrier pre-authorized Alumbar laminectomy fusion instrumentation L1-2 with two-day inpatient,@ specifying CPT codes 63047, 22630, and 22842.

5. On October 1, 2002, Eric Scheffey, M.D., an orthopedic surgeon associated with Provider, performed spinal surgery on Claimant.

6. Provider's October 1, 2002 surgery on Claimant included exploration of spinal fusion, muscle myocutaneous or fasciocutaneous flap, adjacent tissue transfer or rearrangement more than 30 square centimeters unusual or complicated in any area, laminectomy facetectomy/foraminotomy single vertebral segment thoracic, laminectomy with decompression of nerve roots, including partial facetectomy and foraminotomy and/or excision of herniated intervertebral lumbar, laminectomy facetectomy/foraminotomy single vertebral segment each additional segment cervical thoracic or lumbar, posterior segmental instrumentation 3 to 6 vertebral segments, arthodeses lat transverse with graft-int fixa lumbar and arthrodesis-post-lat-tech-each additional interspace.

7. Provider requested reimbursement for services performed under 11 CPT codes, including only one of the three pre-authorized CPT codes.

8. Carrier paid Provider $4,687 for services rendered under CPT code 22842, which was pre-authorized, and CPT codes 22852 and 20975, which were not pre-authorized but which were within the scope of the pre-authorized surgery.

9. Provider disputes Carrier's denial of reimbursement for services billed under CPT codes 22830, 63046, 63042, 63048, 22625, 22650, 15734, and 14300, for a total of $13,295.

10. The disputed procedures performed on Claimant by Provider on October 1, 2002, were not pre-authorized, and were not reasonable or medically necessary to treat Claimant's compensable injury or to reduce his back and leg pain.

11. Provider filed a Request for Medical Dispute Resolution with the Medical Review Division (MRD) of the Texas Workers' Compensation Commission, seeking additional reimbursement for the spinal surgery.

12. The MRD referred the dispute to an independent review organization (IRO), which agreed on October 16, 2003, with Carrier's position that the procedures in question were not medically necessary.

13. Based on the IRO recommendation, the MRD found on October 22, 2003, that Provider was not entitled to additional reimbursement for the spinal surgery performed on October 1, 2002.

14. On November 13, 2003, Provider filed a request for hearing before the State Office of Administrative Hearings (SOAH).

15. Notice of the hearing was sent December 8, 2003.

16. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

17. The hearing convened on September 14, 2004, with Administrative Law Judge Sharon Cloninger presiding. Susan Towne, account manager for Provider through Indevour Business Services, L.P., represented Provider. James Loughlin, attorney, represented Carrier. The hearing concluded and the record closed that same day.

V. CONCLUSIONS OF LAW

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

1. The State Office of Administrative Hearings (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.

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

3. 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 in accordance with TEX. LAB. CODE ANN. ' 408.021.

4. The disputed surgical procedures were not medically necessary, as medical necessity is defined in TEX. LAB. CODE ANN. ' 408.021.

5. The disputed surgical procedures were not pre-authorized by Carrier, so are not subject to a prohibition of retrospective review, pursuant to 28 TEX. ADMIN. CODE ' 133.301(a).

6. Pursuant to the foregoing Findings of Facts and Conclusions of Law, Provider is not entitled to additional reimbursement for the spinal surgery performed on Claimant on October 1, 2002.

ORDER

IT IS, THEREFORE, ORDERED that East Harris County Orthopedic Associates, P.A. is not entitled to additional reimbursement from Continental Casualty Insurance for the October 1, 2002 spinal surgery performed on Claimant ____

SIGNED November 10, 2004.

_____

SHARON CLONINGER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS