DOCKET NO. 453-04-3775.M4
MR NO. M4-03-7121-01

KENNETH BERLINER, M.D., **Petitioner**	'	**BEFORE THE STATE OFFICE**
V.	'	**OF**
BRITISH AMERICAN INSURANCE COMPANY, **Respondent**	'	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Kenneth Berliner, M.D., requested a hearing from a decision of the Texas Workers' Compensation Commission's Medical Review Division (MRD) denying his claim for additional reimbursement for treating Claimant with a two-level intra-discal electro-thermal (IDET) procedure. The MRD found that Dr. Berliner failed to submit billing and payment records to challenge the amount British American Insurance Company (Carrier) paid for this procedure. After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that Dr. Berliner is not entitled to further reimbursement.

I. JURISDICTION AND PROCEDURAL HISTORY

The Texas Workers' Compensation Commission (TWCC/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.

The hearing was convened and closed May 25, 2004, at SOAH facilities in Austin, Texas. Administrative Law Judge (ALJ) Catherine C. Egan presided. Steven Tipton, attorney, represented British American Insurance Company. Dr. Berliner appeared *pro se*.[1]

II. BACKGROUND OF THE CASE

On ___, Claimant suffered a compensable injury to the back. In an effort to relieve Claimant's chronic pain from that injury, Dr. Berliner, a board-certified orthopedic surgeon, performed a two-level IDET procedure on Claimant at spine levels L5-S1 (first level) and L4-L5 (second level) on September 25, 2002. Dr. Berliner billed $9,875.00 for each level treated (a total of $19,750) under Code 22899, the code for an unlisted spinal surgery procedure.

Carrier, the insurer for Claimants employer, paid Provider $1,643.75 for one level, and half for the second level, for a total of $2,465.63. Subsequently, Carrier asserted that it should not have paid anything for the second level under the premise that both levels are covered as one procedure. Carrier asked to be reimbursed $821.88.

Dr. Berliner requested medical dispute resolution. The MRD issued a decision in the dispute on January 20, 2004, finding against Dr. Berliner. According to the MRD, Dr. Berliner failed to submit billing and payment records to support his fee dispute in accordance with Section 413.011(b) of the Act and to show that the amount paid was not fair and reasonable. Dr. Berliner made a timely request for hearing of the MRD decision.

[1] Dr. Berliner appeared telephonically.

III. EVIDENCE AND ARGUMENTS

Medical necessity is not in issue; only the amount to be reimbursed is in dispute. Because MRD found against Dr. Berliner, he bears the overall burden of proof.

Dr. Berliner argued that Carrier paid a lower amount for the IDET procedure than the industry average; changed the reimbursement code in violation of Rule 133.301; did not explain its methodology in calculating the amount paid; and improperly denied full payment for the second procedure. According to Dr. Berliner, the second level (L4-L5) was at a remote site and should have been paid separately from the first level (L5-S1).

While acknowledging that the $9,875.00 billed per each IDET procedure was high, Dr. Berliner testified that he has billed this amount, or more, in the 80 IDET procedures he has performed between 2000 and 2002. According to Dr. Berliner, carriers paid 24 of these bills without adjustment, with the average paid being $5,005. Therefore, Dr. Berliner contends, the market value for the IDET procedure is $5,005. Dr. Berliner did not offer his bills into evidence to verify the accuracy of his testimony. Although asked on cross-examination, Dr. Berliner did not know the median amount paid. He agreed that a fair and reasonable price to charge for the IDET procedure was $5,005, not the amount he charged. Nonetheless, he did not reimburse the difference to those carriers who paid more.

Dr. Berliner also criticized the methodology Carrier used to calculate its payments for IDET services. Carrier found the IDET procedure to be comparable to a percutaneous diskectomy (CPT Code 62287), which has a maximum allowable reimbursement (MAR) of $1,315. Carrier reimbursed Dr. Berliner $1,643.75, 125 percent of the amount for a percutaneous diskectomy. Dr. Berliner asserted that the IDET procedure is more difficult and time-consuming, with added complexities and risks, and should be paid at a higher rate.

Carrier asserts that this rate of reimbursement is fair and reasonable based on billing and payment research, and is in accordance with Section 413.011(b) of the Act. Nick Tsourmas, M.D.,[2] Carrier's expert, testified that Dr. Berliner correctly billed the procedure under CPT Code 22899, but disagreed with the amount billed. According to Dr. Tsourmas, the proper amount to bill for an IDET is only $506, the same amount permitted under CPT Code 62292, an analogous procedure.

CPT Code 62292 covers an injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar, with a maximum allowable reimbursement (MAR) of $506. Dr. Tsourmas explained that the IDET procedure and the procedure set out in CPT Code 62292 involve placing a cannula into a disk and require similar training, expertise, and experience. The percutaneous diskectomy, Dr. Tsourmas maintains, is more arduous.

According to Carrier, 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 a percutaneous diskectomy, a similar procedure, and adjusting it upward. Dr. Tsourmas found the $10,000-per-level fee sought by Dr. Berliner to be grossly excessive and affirmed that the Carrier's methodology was fair and reasonable.

Dr. Berliner further contends that Carrier 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. Because of the lack of documentation, it is unclear what actually happened. Although Carrier apparently relied on a different billing code from that initially cited in Dr.

[2]Dr. Tsourmas, a board-certified orthopedic surgeon, has served on a number of the Commission's advisory committees.

Berliner's bill in calculating the amount to reimburse Dr. Berliner, nothing in the record establishes that Carrier changed Dr. Berliner's billing code. Moreover, the code used by Dr. Berliner did not have its own MAR.

Dr. Berliner also challenged Carrier's use of the Multiple Procedure Reimbursement Rule[3] for the second level of the IDET procedure. According to Dr. Berliner, his treatment on each disk level should be considered as a separate IDET procedure. Dr. Berliner explained that, because the disks were not related (L4-L5 was a remote area from L5-S1), the procedure required the repetition of all major steps; and because the treatment of the disk at one level did not affect the treatment of the disk at the other level, it should be paid as two separate procedures.

Carrier disagreed, arguing that the IDET procedure is uncomplicated. In this case, the IDET procedure for both levels of the spine was done at the same time and within an hour; involved the same preoperative preparation and post operative care, involved the same anesthesia, the same operating room, and shared many other expenses. Dr. Berliner offered insufficient evidence to show that the Multiple Procedure Reimbursement Rule should not apply.

IV. ALJ'S DISCUSSION

Dr. Berliner failed to meet his burden of proof in this case, providing no credible evidence to show that his charges for the IDET procedure were fair and reasonable, as defined by pertinent statutory and regulatory criteria.[4] In fact, Dr. Berliner concedes that the amount he bills is not fair and

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[3] 1996 *MFG* Surgery Ground Rules (1)(D)(1)(b).

[4] Section 413.011(d) of the Act, provides:

> 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

reasonable, acknowledging instead that a fair and reasonable charge for this procedure should be $5,005. The ALJ finds that Dr. Berliner failed to offer credible evidence to show that he was entitled to additional reimbursement. Dr. Tsourmas' testimony, explaining the Carrier's methodology in calculating reimbursement for the IDET procedure, establishes that the methodology is fair and reasonable.

Dr. Berliner failed to prove that Carrier changed his billing code in violation of 28 TAC 133.301(b). Nothing offered into evidence showed that the Carrier changed Dr. Berliner's billing code. Indeed, Carrier used CPT code 62287 in developing a methodology for reimbursement because the IDET did not have a MAR and the services set out in CPT code 62287 and the IDET procedure are similar. Dr. Berliner billed the IDET procedure under the CPT code 22899, which does not identify a particular procedure or a specific amount of appropriate reimbursement. Instead, it indicates that no specific code or MAR applies to the procedure in question. Therefore, the ALJ finds Carrier did not change Dr. Berliner's billing codes in assessing the amount to reimburse.

After Carrier paid Dr. Berliner for both levels of the procedure, Carrier determined no reimbursement should have been paid for the second level of the IDET procedure (L4-L5) and requested reimbursement for $821.88. Carrier contends that both levels are covered by one IDET procedure relying on the MARs for CPT codes 62287 and 62292. CPT codes 62287 and 62292 specify that both single and multiple levels of treatment are included as one procedure. Dr. Berliner testified that he had to repeat most of the basic elements of the IDET procedure in treating each disk level and should have been reimbursed the full amount for two separate IDET procedures, one at L5-S1 and the other at L4-L5.

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subtitle in establishing the fee guidelines.

Carrier's argument that because treatment of multiple levels of the spine are included as one procedure in CPT codes 62287 and 62292, it follows that multiple levels should be embraced as one IDET procedure, is not persuasive. While the treatments set out in CPT codes 62287 and 62292 were similar to the IDET procedure, they are not exactly the same. The reasons for including multiple spine levels of treatment in the reimbursement of CPT codes 62287 and 62292 is unclear. Therefore, without further evidence, the ALJ will not assume that treatment to multiple spine levels should be reimbursed as one IDET procedure.

The Carrier correctly used the Multiple Procedure Reimbursement Rule in paying fifty percent of the applicable rate for the second level (L4-L5) of treatment. The IDET procedures on these two adjacent levels were almost identical, and combined took less than an hour to perform. They involved the same preoperative preparation, the same anesthesia, and the same postoperative care. The ALJ concludes that Dr. Berliner did not demonstrate that the Carrier incorrectly applied the Multiple Procedure Reimbursement Rule.

Dr. Berliner did not meet his burden to prove by a preponderance of the evidence that his charges for the IDET services in dispute were fair and reasonable or that he is entitled to additional reimbursement. Accordingly, the relief sought by Dr. Berliner is denied.

V. FINDINGS OF FACT

1. Claimant suffered a compensable injury to the back on____.

2. In an effort to relieve Claimant's chronic pain from the injury, Dr. Kenneth G. Berliner (Provider) performed a two-level intra-discal electro-thermal (IDET) procedure upon the L5-S1 disk (first level) and L4-L5 (second level) on September 25, 2002.

3. Provider billed the procedures at $9,875 per level treated (a total of $19,750) under CPT code 22899.

4. CPT code 22899 is for an unlisted procedure for spinal surgery and has no set maximum allowable reimbursement (MAR).

5. British American Insurance Company (Carrier), the insurer for Claimant's employer, reimbursed Provider $2,465.63 ($1,643.75 for the first level and half for the second) for the IDET procedures on the basis that this amount represented the fair and reasonable reimbursement for such services.

6. Carrier paid Provider fifty percent of the applicable rate ($1,643.75) for the second level, the amount of $821.88.

7. Provider subsequently sought medical dispute resolution before the Texas Workers' Compensation Commission (Commission).

8. On January 20, 2004, the Commission's Medical Review Division (MRD) issued a decision confirming that Carrier's reimbursement in this case was fair and reasonable because Provider failed to submit his billing and payment records to show that the amount paid by Carrier was not fair and reasonable.

9. Provider made a timely request for hearing of the MRD decision before the State Office of Administrative Hearings (SOAH).

10. After proper notice, a hearing in this action was convened and closed before SOAH on May 25, 2004.

11. The Commission's Medical Fee Guideline (MFG), 28 TEX. ADMIN. CODE (TAC) §134.201, does not include a specific CPT code for the IDET procedure, and no Commission rules or guidelines define MAR for these services.

12. Carrier based its level of reimbursement on a CPT code that described procedures entailing similar work, knowledge, skill, and risk to those entailed in IDET procedures, CPT code 62287.

13. CPT code 62287 addresses a percutaneous diskectomy with a maximum allowable reimbursement of $1,315.

14. Based upon its finding that the IDET procedure and the procedure addressed in CPT code 62287 are similar, and adjusting for the difference between the procedures, Carrier reimbursed the IDET procedures performed upon Claimant at $1,643.75 for the first level and $821.88 for the second level.

15. Carrier adjusted the amount reimbursed to Dr. Berliner by paying 125 percent of the MAR for a percutaneous diskectomy.

16. Carrier requested Provider remit the amount paid for the second level of the IDET procedure (L4-L5) arguing that both spinal levels should be paid as one procedure.

17. While differences exist between an IDET and the CPT code 62287 procedures, the similarities between the two procedures justify Carrier's reliance on this code, as it requires similar skill, work, and risk.

18. Carrier properly applied the Multiple Procedure Reimbursement Rules in reimbursing Provider fifty percent of the amount paid for the first spine level of the IDET procedure.

19. Provider provided no basis for his billing, conceding that he was billing almost fifty percent more than the $5005 he believed was a fair and reasonable amount to bill for the IDET.

VI. 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") at 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. Provider, 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, Carrier appropriately relied upon the MAR for CPT code 62287 to determine 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.

7. Based upon the foregoing Findings of Fact and Conclusions of Law, Provider's request for additional reimbursement is unsupported and should not be approved.

ORDER

IT IS, THEREFORE, ORDERED that the request of Kenneth Berliner, M.D., for additional reimbursement for a two-level IDET procedure is denied.

SIGNED August 18, 2004.

CATHERINE C. EGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS