SOAH DOCKET NO. 453-05-4323.M4
TWCC MDR NO. M4-03-5721-01
SOAH DOCKET NO. 453-05-4324.M4
TWCC MDR NO. M4-03-5737-01

TEXAS MUTUAL INSURANCE COMPANY, **Petitioner**	:	**BEFORE THE STATE OFFICE**
V.	:	**OF**
TEXAS BACK INSTITUTE **Respondent**	:	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

In Docket No. 453-05-4323.M4 Texas Mutual Insurance Company (TMIC) requested a hearing to contest the January 28, 2005 Findings and Decision of the Texas Workers' Compensation Commission (Commission). In this fee dispute, the Commission ordered reimbursement to Texas Back Institute (TBI) for services provided to injured worker ___ (Claimant ___) on June 3, 2002.

In Docket No. 453-05-4324.M4 TMIC requested a hearing to contest the January 28, 2005 Findings and Decision of the Commission. In this fee dispute, the Commission ordered reimbursement to TBI for services provided to injured worker ___ (Claimant ___) on June 10, 2002.

The two dockets were joined for hearing on the merits and decision. TMIC had the burden of proof in each of the two dockets.

After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) concludes that TBI is not entitled to reimbursement for CPT Codes 63090-52, 63090-80, 63090-62, 63091-52 or 63091-80.

The hearing convened on November 29, 2005, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Patricia Eads represented TMIC, and John Fowler represented TBI. Clark Watts, M.D., J.D., testified at the request of TMIC. Neither party objected to notice or jurisdiction. The hearing concluded that day but the record remained open for the filing of a legible version of TBI Exhibit No. 1. The document was filed on December 5, 2005, and the record closed that day.

Claimant ___ suffered a work-related injury to his lumber spine on ___, and underwent an anterior lumbar diskectomy on June 10, 2002, performed by physicians associated with TBI. Claimant ___ suffered a work-related injury on ___, and underwent an anterior lumbar diskectomy on June 3, 2002, performed by physicians associated with TBI.

There is no CPT Code[1] for an anterior lumbar diskectomy.[2] TBI invoiced for a spinal arthrodesis using CPT Code 22558[3] and also invoiced for CPT Code 63090-a vertebral corpectomy.[4] The issues in dispute in these joined proceedings are (1) whether a corpectomy was performed, (2) whether preparation of the endplates for the fusion can be separately billed as a corpectomy, and (3) whether TBI may receive reimbursement for CPT Code 63090 when the CPT code is used as a substitute code for anterior lumbar diskectomy and no vertebral corpectomy was performed. For

[1] Current Procedural Terminology Codes established by the American Medical Association (AMA). The CPT Codes are revised each year by the AMA. The 2002 CPT Codes are applicable in these dockets.

[2] There are CPT Codes for an anterior cervical diskectomy, 63075, and for an anterior thoracic diskectomy, 63077. Diskectomy is also sometimes spelled discectomy.

[3] Lumbar arthrodesis with bone graft. A spinal arthrodesis is a procedure to remove the cartilage of any joint to encourage bones of that joint to fuse, or grow together, where motion is not desired.

[4] The removal of bone.

Claimant ___, TBI requested reimbursement for CPT Codes 63090-52 and 63090-62, as well as 22558-65. For Claimant ___, in addition to CPT Code 22558-65AP, TBI requested reimbursement for CPT Codes 63090-52, 63090-80, 63091-52 and 63091-80.[5] TMIC reimbursed TBI $1795.50 for CPT Code 22558-65 in each instance and refused reimbursement for the corpectomy codes.

Claimant ___'s 360 degree fusion was a "two-staged operative procedure," an anterior procedure followed by a posterior procedure.[6] The June 3, 2002 first operative report was prepared by Barton L. Sachs, M.D.[7] It describes at two levels the anterior procedure, an interbody implant arthrodesis. The report states a complete diskectomy was performed at L5-S1 and then the endplates were penetrated with an angled awl.[8] Following placement of the bone graft into the L5-S1 space, the surgeons repeated the same procedure at the L4-5 disc level.[9] The pathology report for the 360 degree fusion states the specimen labeled "disc L4-S1" consisted of 27 grams of pink and white fibrocartilaginous and scanty osseous tissue.[10] The disc components recognized in the pathology report were annulus fibrosus, nucleus pulposus and hyaline cartilage plate. The second operative report by Dr. Sachs describes the posterior procedure.[11] In essence, bone was harvested from Claimant ___'s left iliac crest and fused at L4 through S1 using segmental pedicle screw fixation.[12]

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[5] The -52 modifier indicates the health care provider elected to partially reducer or eliminate the procedure. The -62 modifier indicates the use of two surgeons, usually with different skills, sharing a single CPT code. The -65 modifier indicates co-surgeons with each surgeon receiving 75% of the Maximum Allowable Reimbursement (MAR). The -80 modifier is used for an assistant surgeon who receives 25% of the MAR. The -AP modifier indicates combined anterior/posterior spinal procedures. CPT Code 63091 is for each additional segment in which a corpectomy is performed.

[6] TMIC Exhibit 1, Tab 3, p 59.

[7] TMIC Exhibit 1, Tab 3, pp. 56-58.

[8] *Id.* at p. 57.

[9] *Id.*

[10] *Id.* at p. 58A.

[11] *Id.* at pp. 59-62.

[12] *Id.*

Claimant ___'s 360 degree fusion was a similar operative procedure, an anterior procedure followed by a posterior procedure.[13] The June 10, 2002 operative report of surgeon Stephen H. Hochschuler, M.D., though not as detailed as Dr. Sachs', describes the anterior approach, the discectomy, and the anterior infusion.[14] The posterior decompression and fusion is described in Dr. Hochschuler's second operative report of June 10, 2002.[15] The pathology report indicates the specimen labeled "disc L4-S1" consisted of 22 grams of pink and white fibrocartilaginous tissue fragments.[16] The disc components recognized in the pathology report were annulus fibrosus, nucleus pulposus and hyaline cartilage plate.[17]

Neither the operative reports nor the pathology report for Claimant ___ refer to a corpectomy. Neither the operative reports nor the pathology report for Claimant ___ refer to a corpectomy. If bone had been removed from the fusion site, it would have been mentioned in the operative report, and bone would have been identified in the pathology report. Claimant ___'s post-surgical x-rays do not show any portion of bone missing.[18] TMIC witness Nicolas F. Tsourmas, M.D., an orthopaedic surgeon, concluded in his deposition testimony that neither claimant had a corpectomy.[19] Dr. Watts also concluded, in his hearing testimony, that neither claimant had a corpectomy.

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[13] TMIC Exhibit 1, Tab 6, pp. 59-65.

[14] *Id.* at pp. 61-62.

[15] *Id.* at pp. 63-64.

[16] *Id.* at p. 65A.

[17] *Id.*

[18] TMIC Exhibit 1, Tab A, pp. 23-24; hearing on the merits testimony of Dr. Watts.

[19] TMIC Exhibit 1, Tab A, pp. 19-20, 22-24.

The fact that neither claimant had a corpectomy is confirmed by the correspondence of the two principal surgeons, Drs. Sachs and Hochschuler. On November 3, 2005, both Dr. Sachs[20] and Dr. Hochschuler[21] issued written explanations with identical wording to justify their use of CPT Code 63090. They stated that their respective patients had more than the "minimal diskectomy" covered by CPT Code 22558 and that there is no CPT Code for a 'complete' anterior lumbar diskectomy.[22] For these reasons, they looked for other available CPT Codes that "BEST DESCRIBE' the services performed."[23] Because the procedure was an anterior procedure, they did not "feel" that a posterior lumbar diskectomy code was "an appropriate selection."[24] They selected CPT Code 63090[25] "as the code that best describes the procedure performed."[26]

The AMA has generated specific CPT codes for reporting unlisted procedures. Rather than selecting a CPT code that approximates the unlisted procedure or service, the provider should use the unlisted procedure number and also describe the service or procedure.[27] With respect to Medicare billing guidance, in June 2000 the Health Care Financing Administration (HCFA) issued specific instructions with respect to CPT Code 22558.[28] HCFA specifically advised health care providers that when a diskectomy that is 'more than minimal' is performed, the additional service is

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[20] TMIC Exhibit 1, Tab 4.

[21] TMIC Exhibit 1, Tab 5.

[22] TMIC Exhibit 1, Tabs 4 and 5.

[23] *Id.* (Emphasis in original).

[24] *Id.*

[25] CPT Code 63090 reads as follows: "vertebral corpectomy (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." TMIC Exhibit 2, p.2.

[26] *Id.*

[27] TMIC Exhibit 2, p. 2.

[28] TMIC Exhibit 1, Tab 7.

to be reported using a -22 modifier.[29] The operative report must accompany the claim, and the necessity must be documented in the operative report.[30] According to HCFA, the "more than minimal" diskectomy is not to be reported using a CPT code for an unlisted procedure.[31]

The Commission issued Advisory 97-01 on June 13, 1997 (Advisory).[32] The purpose of the Advisory was to provide information to clarify certain provisions of the 1996 Medical Fee Guideline.[33] A portion of the Advisory addresses Surgery Ground Rules I(E)(2)(a), Arthrodesis. The Advisory corrects the rule as adopted in the 1996 Medical Fee Guideline (MFG)[34] by inserting the word "minimal" prior to diskectomy. The corrected guideline reads as follows: "All arthrodesis procedures include those vertebral graft preparations, such as minimal diskectomy, necessary to accomplish the arthrodesis."[35] The Advisory continues:

> Preparation of the arthrodesis site, such as minimal diskectomy, is not separately billable and is considered to be part of the arthrodesis procedure. A full diskectomy procedure may be billed separately if not included as part of the global procedure for arthrodesis. Refer to Global Service Data for Orthopaedic Surgery, revised edition, January 1994, compiled by the American Academy of Orthopaedic Surgeons for services excluded and included in the arthrodesis procedure performed.[36]

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[29] *Id.* at p. 2.

[30] *Id.*

[31] *Id.*

[32] TMIC Exhibit 1, Tab 8.

[33] *Id.* at p. 2.

[34] 28 TEX. ADMIN. CODE 134.201.

[35] TMIC Exhibit 1, Tab 8, p. 3.

[36] *Id.*

The same Advisory also discusses the use of the modifier -22 for unusual services.[37]

> AWhen a service is provided that is greater than that usually required for the listed procedure, the modifier -22 Unusual Services may be used to request reimbursement in excess of that specified in the MFG. Documentation of Procedure (DOP) substantiating the request for increased reimbursement is required.[38]

Neither party supplied the Global Service Data for Orthopaedic Surgery, revised edition, January 1994, compiled by the American Academy of Orthopaedic Surgeons. The document placed in the record was the June 1998 Bulletin of American Academy of Orthopaedic Surgeons.[39] The article by Jeri L. Harris, CPC, CPC-H, is entitled "Solving dilemma of -62, -82 modifiers, How to Code when two surgeons perform part of difficult surgery." The article uses as an example an orthopaedic surgeon and a general thoracic surgeon performing a lumbar diskectomy of L4-5, L5-S1, fusion and instrumentation and iliac crest bone grafting. The article discusses the thoracic surgeon billing a CPT Code 63090 with a -62 modifier if the thoracic surgeon performed the anterior lumbar approach and then assisted in the major portion of the primary procedure, and using a -80 modifier if the thoracic surgeon's services were limited to gaining access for the orthopaedic surgeon's anterior approach for the lumbar diskectomy and then exiting the operating area, returning only for the surgical closure.[40]

TBI finds the article supportive of its position that it is proper to bill for a corpectomy as a substitute code for a full diskectomy because the article uses the corpectomy CPT Code 63090 without specifically referencing the performance of a corpectomy during the anterior lumbar diskectomy. TMIC contended the article does not support TBI's position because the article does not specifically state that a corpectomy code may be billed as a substitute for another code when no

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[37] *Id.* at p. 2.

[38] *Id.*

[39] TMIC Exhibit 1, Tab 9.

[40] *Id.* at p. 2.

corpectomy is performed. TMIC contends the reader must assume that a corpectomy was performed.

Because the article does not expressly address the issue in dispute in this docket and because the determinative value of the article is based solely upon the assumption of the reader, the ALJ finds the article of no evidentiary value.

The ALJ finds that it was not appropriate for TBI to charge for a CPT Code 63090 vertebral corpectomy based on its conclusion that the CPT code best described the unlisted complete anterior lumbar diskectomy procedure. The course TBI elected to follow is not sanctioned by the Commission, by the AMA or by HCFA.

While TBI appears to contend that endplate chiseling qualifies as a corpectomy,[41] the ALJ finds that removing bony endplate to prepare the bone for fusion is global to, a part of, the arthrodesis procedure and is not properly billed as a separate corpectomy procedure.

TMIC proved that neither Claimant ___ nor Claimant ___ underwent a corpectomy. Removing bony endplate to prepare the bone for fusion is global to the arthrodesis procedure and is not properly billed as a separate corpectomy procedure. It was not appropriate for TBI to charge for a corpectomy because, in its estimation, CPT Code 63090 best described the unlisted procedure. TMIC proved by a preponderance of the evidence that TBI is not to be reimbursed for CPT Codes 63090-52, 63090-80, 63090-62, 63091-52 or 63091-80.

[41] *See* TBI Exhibit 1, pp. 1 and 4.

II. FINDINGS OF FACT

1. ___ (Claimant ___) suffered a work-related injury on ___.

2. ___ (Claimant ___) suffered a work-related injury on ___.

3. Claimant ___ underwent an anterior lumbar diskectomy on June 10, 2002, performed by physicians associated with Texas Back Institute (TBI).

4. Claimant ___ underwent an anterior lumbar diskectomy on June 3, 2002, performed by physicians associated with TBI.

5. Current Procedural Terminology Codes (CPT Codes) are established by the American Medical Association (AMA). The CPT Codes are revised each year by the AMA. The 2002 CPT Codes are applicable in these dockets.

6. While there are CPT Codes for an anterior cervical diskectomy, 63075, and for an anterior thoracic diskectomy, 63077, there is no CPT Code for an anterior lumbar diskectomy.

7. TBI invoiced the anterior lumbar diskectomy using CPT Code 22558, lumbar arthrodesis with bone graft, and also invoiced for CPT Code 63090-a vertebral corpectomy.

8. CPT Code 22558 involves a minimal discectomy.

9. A corpectomy involves the removal of bone.

10. CPT Code 63090 was invoiced to achieve reimbursement for more than a minimal diskectomy.

11. For Claimant ___, TBI requested reimbursement for CPT Codes 63090-52 and 63090-62, as well as 22558-65.

12. For Claimant ___, in addition to CPT Code 22558-65AP, TBI requested reimbursement for CPT Codes 63090-52, 63090-80, 63091-52 and 63091-80. CPT Code 63091 is for each additional segment in which a corpectomy is performed.

13. Texas Mutual Insurance Company (TMIC) reimbursed TBI $1795.50 for CPT Code 22558-65 in each instance and refused reimbursement for the corpectomy codes.

14. Both Claimant ___ and Claimant ___ underwent a 360-degree fusion performed as a two-stage operative procedure, an anterior procedure followed by a posterior procedure.

15. Operative reports for each stage of each claimant's operative procedure were prepared by the appropriate surgeons.

16. Pathology reports were prepared for each claimant.

17. Neither the operative reports nor the pathology report for Claimant ___ refer to a corpectomy.

18. If bone had been removed from Claimant ___'s fusion site, it would have been mentioned in the operative report and bone would have been identified in the pathology report.

19. Neither the operative reports nor the pathology report for Claimant ___ refer to a corpectomy.

20. If bone had been removed from Claimant's ___'s fusion site, it would have been mentioned in the operative report and bone would have been identified in the pathology report.

21. Claimant ___'s post-surgical x-rays do not show any missing bone that would evidence performance of a corpectomy.

22. Claimant ___'s post-surgical x-rays were not available.

23. A spinal arthrodesis, CPT Code 22558, is a procedure to remove the cartilage of any joint to encourage bones of that joint to fuse, or grow together, where motion is not desired.

24. Removing bony endplate to prepare the bone for fusion is global to the arthrodesis procedure and is not properly billed as a separate corpectomy procedure.

25. Claimant ___ did not undergo a corpectomy.

26. Claimant ___ did not undergo a corpectomy.

27. Barton L. Sachs, M.D., was Claimant ___'s principal surgeon.

28. Stephen H. Hochschuler, M.D., was Claimant ___'s principal surgeon.

29. Drs. Sachs and Hochschuler billed for CPT Code 63090 only because their patients had more than the minimal diskectomy covered by CPT Code 22558.

30. Drs. Sachs and Hochschuler billed CPT Code 63090 because it best described the unlisted anterior lumbar diskectomy procedure.

31. Requesting reimbursement under CPT Code 63090 because it best described an unlisted procedure is not appropriate under the guidelines of the AMA, the Health Care Financing Administration, or the Texas Workers' Compensation Commission (Commission).

32. In Docket No. 453-05-4323.M4 TMIC requested, on February 8, 2005, a hearing to contest the January 28, 2005 Findings and Decision of the Commission ordering reimbursement to TBI for corpectomy services provided to Claimant ___ on June 3, 2002.

33. In Docket No. 453-05-4324.M4 TMIC requested, on February 8, 2005, a hearing to contest the January 28, 2005 Findings and Decision of the Commission ordering reimbursement to TBI for corpectomy services provided to Claimant ___ on June 10, 2002.

34. The two dockets were joined for hearing on the merits and decision.

35. On February 28, 2005, the Commission issued a separate notice of hearing in each docket.

36. Each notice of hearing contained: (1) a statement of the time, place, and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and rules involved; and (4) a short, plain statement of the matters asserted.

37. The hearing convened on November 29, 2005, with State Office of Administrative Hearings (SOAH) Administrative Law Judge Howard S. Seitzman presiding. Patricia Eads represented TMIC, and John Fowler represented TBI.

38. The hearing concluded on November 29, 2005, but the record remained open for the filing of a legible version of TBI Exhibit No. 1. The document was filed on December 5, 2005, and the record closed that day.

III. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. §413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The requests for a hearing were timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.
5. The party requesting the contested case hearing has the burden of proof.

6. TMIC proved by a preponderance of the evidence that TBI is not due reimbursement for CPT Codes 63090-52, 63090-80, 63090-62, 63091-52 or 63091-80.

ORDER

THEREFORE IT IS ORDERED that Texas Back Institute is not entitled to reimbursement from Texas Mutual Insurance Company for June 3, 2002 charges associated with CPT Codes 63090-52 and 63090-62 related to injured worker ___.

IT IS FURTHER ORDERED that Texas Back Institute is not entitled to reimbursement from Texas Mutual Insurance Company for June 10, 2002 charges associated with CPT Codes 63090-52 63090-80, 63091-52 or 63091-80 related to injured worker ___

SIGNED January 17, 2006.

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HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS