SOAH DOCKET NO. 454-08-3351.M4
TWCC MR NO. M4-08-3079-01

MARIO KAPUSTA, M.D.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	
	§	**OF**
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Mario Kapusta, M.D. (Dr. Kapusta or Provider), requested a hearing to contest a decision by the Texas Department of Insurance, Workers Compensation Division (Division), Medical Fee Dispute Resolution Section (MFDR), which determined that Texas Mutual Insurance Company (TMI or Carrier) had properly denied Dr. Kapusta reimbursement for assisting in a spinal surgery. Carrier denied Dr. Kapusta's claim based on its determination that it had already reimbursed him for the services he provided to an injured worker (Claimant), and that he was not entitled to recover for assisting in the surgery. The Administrative Law Judge (ALJ) upholds the Division's decision.

I. PROCEDURAL HISTORY

A hearing convened in this case on October 28, 2008, before the undersigned ALJ at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Dr. Kapusta appeared in person and the Carrier was represented by Attorney Mimi Shelton. Because there are no issues concerning notice or jurisdiction, those matters are stated in the Findings of Fact and Conclusions of Law without further discussion here.

At the October 28, 2008 hearing, Dr. Kapusta offered Provider's Exhibit 1, which was admitted. TMI offered Carrier's Exhibits 1-7, which were admitted. At the close of the hearing, a briefing deadline of November 21, 2008, was set. Thereafter, on November 14, 2008, TMI filed its closing argument and a motion to admit new evidence. On November 20, 2008, Dr. Kapusta filed a request for more time to respond to TMI's closing argument. On November 21, 2008, the ALJ issued Order No. 5, granting the parties until December 8, 2008, to file initial and responsive

briefing regarding TMI's motion to admit new evidence. Although Dr. Kapusta filed briefing responsive to the evidence offered in TMI's motion to admit new evidence, he did not object to the admission of that evidence. TMI's motion to admit new evidence is granted with the issuance of this Decision and Order, and Carrier's Exhibits 8 and 9 are admitted. The record closed on December 8, 2008.

II. DISCUSSION AND ANALYSIS

The Claimant sustained a work-related injury to his back on ____. After a series of treatments, spinal surgery was recommended. Dr. Kapusta provided medical services to the Claimant during his January 19, 2007 spinal surgery. Claimant's spinal surgery was conducted in two stages. First, Dr. Kapusta conducted the exposure and closure of the fusion site at the beginning and end of the surgery, for which he has been reimbursed by Texas Mutual. Those services are not in dispute. Second, Dr. Richard Francis, M.D., conducted the fusion portion of the surgery, for which Dr. Kapusta also seeks reimbursement as an assistant surgeon. TMI disputed Dr. Kapusta's second bill, claiming that it lacked adequate documentation to justify his reimbursement as an assistant surgeon. The disputed services were billed on February 28, 2008, under CPT Codes 22558 and 22585, using the modifier 80 (assistant surgeon).[1] The total amount in dispute is $9,391.00 (Disputed Services). Dr. Kapusta appealed to the Division and the MFDR determined that, based on the documentation submitted by Dr. Kapusta, TMI's denial of reimbursement for the Disputed Services was proper.[2] Dr. Kapusta then appealed the MFDR's decision to SOAH. As the Petitioner, Dr. Kapusta has the burden of proof.

Based on a review of the documents submitted, the ALJ agrees with the Division's decision. Dr. Kapusta billed for the first stage of surgery, using the CPT Code modifier 62.[3] The 62 modifier applies to his services, because the opening and closure of the Claimant was distinct from the fusion stage of the surgery performed by Dr. Francis. The 62 modifier is described as:

> **Two-Surgeons**. When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his distinct operative work by adding the modifier 62. Each surgeon should report the cosurgery once using the same procedure code. An operative report is required from

[1] Carrier Ex. 7 at 438.

[2] Carrier Ex.1 at 2.

[3] Carrier Ex.7 at 1.

both surgeons and it must demonstrate the medical necessity for two surgeons.[4]

It is undisputed that Dr. Kapusta was reimbursed for the opening and closure of the Claimant consistent with modifier 62. In addition, both Dr. Kapusta and Dr. Francis drafted separate operative reports for their distinct duties during the surgery. Dr. Francis and his surgical assistant, Eduardo Fuentes, were reimbursed for the fusion portion of the surgery.[5]

The issue here is that Dr. Kapusta also seeks reimbursement for the fusion stage of the surgery as an assistant surgeon, under the CPT Code modifier 80. An "assistant-at-surgery" is defined as:

> . . . a physician who actively assists the physician in charge of a case in performing a surgical procedure.[6]

TMI argues that the documentation provided by Dr. Kapusta is inadequate to support his reimbursement as an assistant surgeon under CPT Code modifier 80. As noted by TMI, there is only one passage in the doctors' operative reports that supports Dr. Kapusta's claim that he was an assistant surgeon during the fusion stage of the surgery. Dr. Francis' revised operative report identifies the following persons involved in the surgery:

> SURGEON: Richard Francis, M.D.
> CARDIOVASCULAR EXPOSURE SURGEON AND ASST. SURGEON: Mario Kapusta, M.D.
> ASSISTANT SURGEON: Ed Fuentes (certified surgical assistant)[7]

This caption to Dr. Francis' amended operative report is the only documentary evidence that supports Dr. Kapusta's claim for reimbursement as an assistant surgeon. In claims correspondence with TMI, Dr. Kapusta asserted that during the second stage "I remained scrubbed and assisted Dr. Francis in the performance of this portion of the procedure."[8] Yet, Dr. Kapusta's report is silent regarding his assistance. His report only describes the opening and closure of the patient; it lacks any description of services provided during the fusion stage of the surgery. Dr. Kapusta stated at the

---

[4] Carrier Ex. 9, Medicare Guide, Part B, at 22.

[5] *See generally*, Carrier Ex. 9.

[6] Carrier Ex. 9.

[7] Provider's Ex. 1 at 2. As noted by TMI in post-hearing briefing, Dr. Francis' initial reports identified Dr. Kapusta simply as "cardiovascular exposure surgeon." *See generally*, Carrier Ex. 9. Dr. Francis later amended his report to list Dr. Kapusta as an assistant surgeon. The Carrier raises doubts about the veracity of Dr. Francis' revision. The ALJ, however, agrees with Dr. Kapusta that Dr. Francis was entitled to amend his report.

hearing that he could not recall what services he performed during the second stage, only that he remained scrubbed. And other than Dr. Francis'reference to Dr. Kapusta as "Asst. Surgeon," his report is also silent about services provided by Dr. Kapusta. It only notes that "[t]his represents the second stage of a staged surgical procedure," and ends with "[t]he wound was closed in several layers . . ."[9] These are the only two references to work performed by Dr. Kapusta and are limited to his services during the first stage of the surgery.

Under 28 TEX. ADMIN. CODE § 148.14, Dr. Kapusta had the burden of proof to establish that the documentary evidence supported his claim for reimbursement as an assistant surgeon during the fusion stage of Claimant's surgery. As set forth above, under the Medicare Guide Dr. Kapusta must establish that he "actively" assisted "the physician in charge . . . in performing a surgical procedure." There is simply no documentary evidence that Dr. Kapusta actively assisted Dr. Francis in performing the fusion phase of Claimant's spinal surgery. Because Dr. Kapusta's evidence was inadequate to meet his burden of proof, the Division's decision is upheld.

III. FINDINGS OF FACT

1. On ____, ____ (Claimant) suffered an injury compensable under workers' compensation insurance.

2. On the date of injury, Texas Mutual Insurance Company (Carrier) was the workers' compensation insurance carrier for Claimant's employer.

3. On January 19, 2007, Mario Kapusta, M.D. (Provider) performed the opening and closure stage (First Stage) of a two-stage spinal fusion surgery on Claimant as treatment for his compensable injury. Richard Francis, M.D., performed the fusion stage of the Claimant's surgery (Second Stage). Both doctors wrote separate operative reports for their distinct services.

4. On January 29, 2007, the Provider submitted a bill to the Carrier for his medical services rendered in the First Stage.

5. The Carrier reimbursed the Provider $1,577.72 for the First Stage.

6. On February 28, 2007, the Provider submitted a bill to the Carrier for $9,391.00 for services he stated were performed during the Second Stage under CPT Codes 22558 and 22585, using the modifier 80 for "assistant surgeon" (Disputed Services).

---

[8] Provider's Ex. 1 at 55.

[9] Carrier's Ex. 9.

7. The Carrier denied reimbursement to the Provider for the Disputed Services, due to inadequate documentation.

8. When Carrier denied reimbursement for the Disputed Services, the Provider requested medical fee dispute resolution through the Texas Department of Insurance, Division of Workers' Compensation (Division).

9. On May 19, 2008, the Division issued its findings and decision and determined that TMI had properly denied reimbursement to the Provider for the Disputed Services.

10. On June 3, 2008, the Provider requested a hearing by the State Office of Administrative Hearings (SOAH) to appeal the Division's order.

11. On June 13, 2008, the Division sent a notice of the SOAH hearing in this matter to all parties.

12. All parties received adequate notice of not less than 10 days of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

13. On October 28, 2008, SOAH Administrative Law Judge Travis Vickery held a contested case hearing concerning the Disputed Services at the William P. Clements Office Building, Fourth Floor, 300 West 15th Street, Austin, Texas. Provider appeared at the hearing in person and Carrier appeared through its attorney. No other parties appeared or participated in the hearing. The record closed on December 8, 2008.

14. The only evidence of Provider's medical services rendered to the Claimant during the Second Stage is the Provider's identification as "Asst. Surgeon" in Dr. Richard Francis' operative report.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.052.

3. Provider had the burden of proving by the preponderance of the evidence that it was entitled to payment for the Disputed Services. 1 TEX. ADMIN. CODE § 155.41(b); 28 TEX. ADMIN. CODE § 148.14(a).

4. Based on the above Findings of Fact, Provider failed to provide evidence adequate to establish his entitlement to reimbursement for the Disputed Services.

ORDER

THEREFORE, IT IS ORDERED THAT the Carrier is not required to provide any reimbursement to Provider for the Disputed Services.

SIGNED January 9, 2009.

TRAVIS VICKERY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS