

MDR Tracking Number: M5-04-1262-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-9-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the fluoroscopy was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 4/24/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 29<sup>th</sup> day of March 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

March 24, 2004

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-04-1262-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology.

The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a male who sustained a work related injury on \_\_\_\_. On 4/24/03 the patient underwent a caudal epidural steroid injection with fluoroscopic guidance.

#### Requested Services

Fluoroscopy on 4/24/03

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

#### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a male who sustained a work related injury on \_\_\_\_. The \_\_\_ physician reviewer also noted that on 4/24/03 the patient underwent a caudal epidural steroid injection with fluoroscopy guidance. The \_\_\_ physician reviewer indicated that CPT codes 62289 and 76000 (along with others) were billed. The \_\_\_ physician reviewer noted that CPT code 62289 was deleted in 2000 and replaced by 62311. The \_\_\_ physician reviewer explained that CPT code 62311 is used to report a single injection of a diagnostic or therapeutic substance, with or without contrast, into the subarachnoid or epidural space of the lumbar or sacral spine. The \_\_\_ physician reviewer indicated that the contrast may be used for localization or epiduragraphy. The \_\_\_ physician reviewer explained that when an anesthetic is injected, the procedure is also known as a nerve block and performed to relieve chronic pain. The \_\_\_ physician reviewer indicated that CPT code 76000 is used to report the use of fluoroscopy for up to 1 hour by a physician for guidance in visualizing the spine and related structures as well as help localize a specific level of the spine for injection. The \_\_\_ physician reviewer explained that when CPT code 76000 is performed with epidural procedure 62311, it is considered integral to the successful outcome of the 1-hour procedure and does not warrant separate reimbursement. The \_\_\_ physician reviewer also explained that CPT code 76000 is incidental to procedure code 62311 when performed during the same operative session. Therefore, the \_\_\_ physician consultant concluded that the Fluoroscopy performed on 4/24/03 was not medically necessary to treat this patient's condition.

Sincerely,