

MDR Tracking Number: M5-03-1271-01

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. This dispute was received on 1-21-03.

The IRO reviewed outpatient services for Lumbar ESI rendered on 1-23-02 that were denied based upon "U".

The IRO concluded that the following services were medically necessary: A4215, A4645, J3010, J2000, A4550, J3360, J7040 and 00630-46. The IRO concluded that 62289, 72265, 76003, 94760, 99070 times 2 and 99499 were not medically necessary.

The requestor obtained preauthorization for outpatient services for lumbar ESI, CPT codes 76000, 76003, 99070, 72100, and 62310. The insurance carrier violated Commission Rule 133.301(a) by retrospectively denying preauthorized treatment based upon medical necessity. These services will be reviewed in accordance with *Medical Fee Guideline*.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 18, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

The requestor obtained preauthorization for outpatient services for lumbar ESI, CPT codes 76000, 76003, 99070, 72100, and 62310. The following table identifies the preauthorized services that were identified on TWCC-60 table.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
1-23-02	76003	\$60.00	\$0.00	U	\$52.00	Rule 133.301(a)	Operative report service to support billed service was not submitted; therefore, no reimbursement is recommended.
	99070 (X2)	\$10.00	\$0.00	U	DOP	General Instructions GR (IV)	
TOTAL		\$80.00					The requestor is not entitled to reimbursement.

**ORDER.**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for date of service 1-23-02 in this dispute.

This Decision and Order is hereby issued this 3<sup>rd</sup> day of November 2003.

Elizabeth Pickle  
 Medical Dispute Resolution Officer  
 Medical Review Division

June 10, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION  
 Corrected Letter**

RE: **MDR Tracking #: M5-03-1271-01**

\_\_\_ 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. This physician is board certified in neuroradiology. 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 female who sustained a work related injury on \_\_\_\_. The patient reported that while at work she experienced the onset of severe low back pain. The patient underwent an MRI 12/9/99 that showed minimal posterior annular bulging at L4/5 and L5/S1 and a probable vertebral hemangioma in the body of T12. The patient underwent lumbar epidural steroid injection treatment, 3<sup>rd</sup> series, under IV sedation.

#### Requested Services

Injections, surgical trays, needles, infusion, anesthesia, myelography, material supplies, electrocardiogram, pulmonary studies, and unlisted evaluation on 1/23/02.

#### Decision

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

#### Rationale/Basis for Decision

The \_\_\_ physician consultant has concluded that the injections, surgical trays, needles, infusion, anesthesia, myelography, material supplies, electrocardiogram, pulmonary studies, and unlisted evaluation on 1/23/02 were not the services billed on 1/23/02. The \_\_\_ physician reviewer explained that CPT code 62289 is a deleted code and is not valid. The \_\_\_ physician reviewer indicated that CPT code 72265 indicates that a Myelography, lumbosacral, radiologic supervision and interpretation were performed. The \_\_\_ physician reviewer explained that a Myelogram entails intrathecal injection of contrast material and this was not done. The \_\_\_ physician reviewer noted that the contrast material was injected into the epidural space. The \_\_\_ physician reviewer also noted that the operative note from 1/23/02 does not document that a Myelogram was performed. The \_\_\_ physician reviewer indicated that CPT code 76003 would indicate that fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device) was performed. The \_\_\_ physician reviewer explained that this code is not applicable to the spine since CPT code 76005 should be used for fluoroscopy of the spine. The \_\_\_ physician reviewer indicated that CPT code 94760 would indicate that pulse oximetry was performed. The \_\_\_ physician reviewer explained that a pulse oximeter is routinely used with conscious sedation. However, the \_\_\_ physician reviewer also explained that it is not usually billed separately and is a part of CPT code 00630-46.

The \_\_\_ physician reviewer indicated that CPT code 99070 would indicate that supplies and materials were provided by the physician over and above those usually included with the office visits or other services rendered. The \_\_\_ physician reviewer explained that the documentation provided does not support the use of this CPT code. The \_\_\_ physician reviewer indicated that CPT code 99499 would indicate that unlisted evaluation and management were performed. The \_\_\_ physician reviewer explained that the documentation provided does not support the use of this CPT code. The \_\_\_ physician reviewer indicated that CPT code A4645 would indicate that contrast was used during this procedure. The \_\_\_ physician reviewer explained that contrast was used and this is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code J2000 would indicate that Lidocaine was used. The \_\_\_ physician reviewer explained that Lidocaine was used and this was an appropriate charge. The \_\_\_ physician

reviewer indicated that CPT code J3010 would indicate that Fentanyl was used during this procedure. The \_\_\_ physician reviewer explained that conscious sedation was used although not specifically stated in the report that Fentanyl was used, it's reasonable to believe that it is was used and this is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code A4550 would indicate that surgical trays were used in this procedure. The \_\_\_ physician reviewer explained that surgical trays were used and this is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code J3360 would indicate that Diazepam was used during this procedure. The \_\_\_ physician reviewer explained that mild sedation was used and this is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code J7040 would indicate that Normal Saline was used in this procedure. The \_\_\_ physician reviewer explained that this was documented as being used and is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code J2765 would indicate that Reglan was used during this procedure. The \_\_\_ physician reviewer explained that there is no documentation that this medication was used and is not a routine portion of conscious sedation. The \_\_\_ physician reviewer also explained that this is not an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code 00630-046 would indicate the use of anesthesia during this procedure. The \_\_\_ physician reviewer explained that there is documentation that anesthesia was used and that this is an appropriate charge. The \_\_\_ physician reviewer indicated that CPT code A4215 would indicate the use of needles in this procedure. The \_\_\_ physician reviewer explained that needles were used in this procedure and this is an appropriate charge. Therefore, the \_\_\_ physician consultant concluded that the use of CPT codes A4215, A4645, J3010, J2000, A4550, J3360, J7040, and 00630-46 were medically necessary for treatment of this patient's condition on 1/23/02. However, the \_\_\_ physician consultant also concluded that the use of CPT codes 62289, 72265, 76003, 94760, 99070 times 2 and 99499 were not medically necessary to treat this patient's condition on 1/23/02.

Sincerely,