

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 (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 January 12, 2004.

The 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 facet injections (64442 & 64443), fluoroscopy, intravenous infusion, intravenous infusion each additional hour, supplies, and materials, requested report, unlisted services, unlisted evaluation, supply of high dose contrast material, unclassified drug, unlisted evaluation, steroid injection (J1040) and (J3010) injection were 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 Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above was not found to be medically necessary, reimbursement for dates of service from 02-04-03 to 02-17-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 17<sup>th</sup> day of March 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

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

**Date:** March 12, 2004

**MDR Tracking #:** M5-04-1398-01

**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Anesthesiologist/Pain Management reviewer (who is board certified in Anesthesiology/Pain Management) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Clinical History**

The patient injured herself on \_\_\_ while moving a patient, and suffered a strain to her right shoulder, her cervical spine, and lumbar spine. Initial and subsequent MRI scan imaging revealed no abnormalities. The patient's interventional treatment has been excessive for this condition. She has undergone multiple sets of epidural steroid injections, trigger point injections and facet injections with indeterminate results. Diagnoses provided by the treating doctor varied among acute S1 radiculopathy, chronic S1 radiculopathy, and acute cervical radiculopathy.

Ultimately, on 1/3/03 she was given a diagnosis of lumbar facet syndrome by the treating doctor. Physical exam findings on that date were very non-specific. Exam noted tenderness over the "facet areas." No lumbar extension or range of motion testing was performed. No specific lumbar facet joint levels were palpated or identified. Following this, she underwent bilaterally, five level, facet joint medial branch nerve blocks on 2/4/03, 2/10/03 and 2/17/03. Each injection was documented to have included "epidurography," despite the fact that the epidural space was not injected. The charge for the procedure included ten separate charges for each epidurogram. An "epidurogram" report was done, but again no epidural space findings were noted.

On 2/6/03, 2 days after the first medial branch nerve injections, the patient returned in severe pain, with her subjective report documented in treating doctor's chart as "pain has worsened." She had a hematoma from the extensive injections. Despite this, the injections were repeated on 2/10/03 and 2/17/03. Each of these injections again included bilateral, five level medial branch nerves, and 10 separate epidurogram charges. No specific diagnostic interpretation of the results was given, other than a statement by the treating doctor that the patient had subjective "60-70% relief."

### **Requested Service (s)**

Facet injections (64442 & 64443), fluoroscopy, intravenous infusion, intravenous infusion each additional hour, supplies and materials, requested report, unlisted services, unlisted evaluation, supply of high dose contrast material, unclassified drug, unlisted evaluation, steroid injection (J1040) and (J3010) injection.

### **Decision**

I agree with the insurance carrier that the services in dispute were not medically necessary.

### **Rationale/Basis for Decision**

I disagree with the diagnosis of lumbar facet syndrome in this patient. No physical exam findings for facet syndrome were present, and no rationale for how facet syndrome might have developed \_\_\_ after her injury is given.

Clearly the patient did not have any relief at 48 hours following the initial injection on 2/4/03. The treating doctor's appeal narrative of 7/3/03 failed to note this. Further, the patient had undergone facet medial branch nerve blocks, as opposed to facet joint blocks, and medial branch nerve blocks should have been efficacious immediately following the injection as a result of the local anesthetic blocking the innervation to each joint, and this result should have been documented.

It is excessive, non-specific, and generally considered outside the standards of sound clinical practice to perform five level, bilateral, facet medial branch nerve blocks in one setting. ISIS protocol and AMA-CPT protocol, published first in 2001, calls for no more than 2 facet joints to be injected in one setting, in order to accurately assess the response to the injection. In the case of medial branch nerves, there are two nerves innervating each joint, one coming from the dorsal spinal nerve above the joint being blocked and

one at the level being blocked. By injecting the medial branch nerves from L2 – S1, essentially three joints on each side for a total of six joints were blocked.

In addition to the above, there are apparent coding irregularities in the charges for multiple epidurograms and multiple fluoroscopic guidance codes. No epidurograms were in fact performed during those procedures. These charges suggest “unbundling.” As documented in AMA-CPT guidelines and ISIS guidelines, each joint has two medial branch nerves supplying it, so the accurate way to code this procedure, if in fact it had been indicated, would have been 64442-50 and 64443-50 X 2.

In terms of the HCPS codes, it would have been appropriate to use either 90780 or 90781 but not both. The same applies to the use of 99070 twice. This would not have been indicated. 99080 is the TWCC-73 code and is appropriate. A4643 is the contrast code and is appropriate. J3490 is for the Bupivacaine, and incredibly, the charge was listed fifteen (15) times for each procedure date of service for a charge of \$595.00. This is quite excessive. It would not be usual and customary to charge multiple times for a single-use bottle of Bupivacaine.

In terms of the recovery room charge (99499), there is no accompanying documentation to support what services and monitoring and staffing were provided in the recovery room to justify the charge. The only statement given is that the patient had “a period of monitored observation.” Did the monitoring include the minimal ASA-approved physiologic monitors (EKG, pulse oximetry, blood pressure)? Was the staffing with ACLS-certified RN’s? Was the time in the recovery room documented? Does the facility meet any accepted standard of safety criteria? Based on the documentation, the recovery room charge is not medically reasonable and necessary.