STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Kuldip Deogun, MD
Petitioner

File No. 21-1150

v

Auto-Owners Insurance Company
Respondent

Issued and entered
this 20th day of September 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 26, 2021, Kuldip Deogun, M.D. (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Auto-Owners Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Respondent issued the Petitioner a written notice of the Respondent's determination under R 500.64(1) on July 21, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the date of service at issue.

The Department accepted the request for an appeal on August 3, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on August 3, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent did not file a reply to the appeal.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal. The IRO submitted its report and recommendation to the Department on September 5, 2021.

II. Factual Background

This appeal concerns the denial of payment for paravertebral facet joint injections rendered on May 6, 2021. The Current Procedural Terminology (CPT) codes at issue are 64490 for a spinal nerve block injection, in addition to 64492 and 64491, described as add-ons for diagnostic nerve block injections.

With its appeal request, the Petitioner submitted supporting documentation indicating that the injured person experienced chronic back pain since a June 2020 motor vehicle accident in which she sustained a thoracic compression fracture. The medical documentation submitted by the Petitioner also indicated the following diagnoses for the injured person: thoracic spondylosis, degenerative disc disease, and thoracic facet syndrome.

In a statement submitted with its appeal request, the Petitioner stated that the injections on the date of service at issue were rendered following an initial diagnostic facet block that was performed on March 21, 2021 and which provided only short-term pain relief. The Petitioner explained in its supporting statement that it ordered a second diagnostic injection to assess the injured person for Radio Frequency Ablation (RFA) as her back pain had returned. In addition, the Petitioner stated that a Magnetic Resonance Imaging (MRI) study of the thoracic spine from January 23, 2021 confirmed there was no central or foraminal narrowing "to support the need for an epidural steroid injection."

The Petitioner's request for an appeal stated:

> Our hope was to assess [the injured person] for RFA to offer her longer lasting pain relief versus an epidural steroid injection. [The injured person] did physical therapy from September 2020 to December 2020 and it offered minimal relief; she has also tried non-steroidal anti-inflammatory drugs (NSAIDs) and muscle relaxers to manage her pain and [that] offered minimal relief as well.

The Respondent did not provide the Department with a reply to the Petitioner's appeal. In its determination issued July 21, 2021, the Respondent noted that there was no support for the medical necessity or appropriateness of the diagnostic injections performed on the date of service at issue, citing Official Disability Guidelines (ODG) for back pain.

III. Analysis

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding inappropriate treatment and overutilization.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, the treatments rendered on the date of service at issue were medically necessary in accordance with medically accepted standards as defined by R 500.61(i).

The IRO reviewer is board-certified in pain medicine and anesthesiology. In its report, the IRO reviewer referenced R 500.61(i), which defines "medically accepted standards" as the most appropriate practice guidelines for the treatment provided. These may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, board, and associations. The IRO reviewer relied on the Practice Guidelines for Spinal Diagnostic & Treatment Procedures, updated comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain, and guidelines from the Centers for Medicare and Medicaid Services.

The IRO reviewer opined that "based on generally accepted standards of [the] specialty of pain management, as well as state and federal standards of care and medical necessity, [the Petitioner] provided a medically necessary treatment on May 6, 2021." The IRO reviewer stated that the ODG standards referenced by the Respondent in its determination "represent a break from the generally understood standard of care for thoracic back pain emanating from facet joints as taught and understood within the specialty of pain management." The IRO reviewer explained:

> The statement that "no more than one set of facet blocks" is needed as stated in the ODG and repeated by [the Respondent] is not supported by any pain management specialty guidelines nor is it supported by Medicaid/Medicare coverage guidelines and, therefore, is non-supportive of the decision not to cover a second diagnostic facet joint nerve block. In addition, the statement that medial branch blocks and/or radiofrequency ablation or rhizotomy is "not recommended" in the thoracic spine is not supported by any pain management society..."

The IRO reviewer explained that "multiple pain management specialty societies recommend that a medial branch block be used in a diagnostic manner to better understand how much pain is emanating from the facet joint" and that if the first procedure provides greater than 80 percent improvement in pain, then current practice guidelines support a "second confirmatory diagnostic block to rule out a false positive." The IRO reviewer explained that if both procedures indicate greater than 80 percent improvement, then a radio frequency ablation may be appropriate. The IRO reviewer opined that, in relation to the treatment at issue, the Petitioner "proceeded in a generally acceptable manner that is the standard of care in the evaluation of this type of pain."

The IRO reviewer opined that the paravertebral facet joint injections provided to the injured person on the date of service at issue were medically necessary and "should be approved in order to best treat [the injured person's] thoracic back pain in the generally acceptable professional standard of care." The IRO

further stated that the treatment was not overutilized in frequency or duration based on pain management specialty guidelines and Medicaid/Medicare coverage guidelines.

Based on the above, the IRO reviewer recommended that the Director reverse the Respondent's determination that the treatments provided to the injured person on May 6, 2021 were not medically necessary in accordance with medically accepted standards and were overutilized in frequency or duration, as defined by R 500.61(i).

IV. ORDER

The Director reverses the Respondent's determination dated June 21, 2021.

The Petitioner is entitled to payment in the full amount billed and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order. This order is subject to judicial review as provided in section 244(1) of the Code, MCL 500.244(1).

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford