STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Specialized Homecare Advent
Petitioner **File No. 21-1265**
v

Auto Club Group Insurance Company
Respondent

Issued and entered
this 5th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On August 11, 2021, Specialized Homecare Advent (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 Club Group Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, and the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on July 22, 2021. The Petitioner seeks reimbursement in the amount of $4,502.87, which is the difference between what the Petitioner billed and what the Respondent reimbursed for the dates of service at issue.

The Department accepted the request for an appeal on August 27, 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 27, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on September 17, 2021.

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 November 11, 2021.

II. Factual Background

This appeal concerns the appropriate reimbursement amount for durable medical equipment and supplies rendered on July 2, 2021, under Healthcare Common Procedure Coding System (HCPCS) Level II codes A4927, A4402, A6212, and A6402, which are described as gloves, lubricant, wound cover, and foam dressing and gauze, respectively. In addition, this appeal concerns the denial of payment for durable medical equipment (DME) rendered on July 2, 2021, under HCPCS code A4606, which is described as a replacement oxygen probe for use with an oximeter device. In its denial, the Respondent determined that the device was not medically necessary.

With its appeal request, the Petitioner submitted a certificate of medical necessity completed by a medical doctor which describes the injured person's supply needs. The Petitioner stated that "[t]his [injured person] has lifetime PIP benefits not subject to Medicare, as [the Respondent] is primary. We have submitted charge master several times, and the items should not be disputed which reflects the charge master."

In its *Explanation of Benefits,* the Respondent denied payment for the date of service at issue on the basis that the billed codes "represents a Medicare status P indicator (bundled/excluded codes)." In addition, the Respondent denied payment for A4606 on the basis that it was not medically necessity and was overutilized. In its reply, the Respondent indicated that a Charge Description Master was not provided by the Petitioner. The Respondent further explained, "[o]n September 7, 2021, upon review of the additional documentation submitted with this Appeal, including the [Petitioner's] [Charge Description Master], the [Respondent] issued an additional payment in the amount of $556.32."[1]

Accordingly, the remaining issue for resolution in this case is whether the product supplied under HCPCS code A4606 was medically necessity based on medically accepted standards.

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

[1] With its additional payment, the Respondent reaffirmed its position that codes A4927, A4402, A6212, and A6402 remained inappropriate for reimbursement based on cost. The Department is unable to determine the merits of the Respondent's assertion, however, because the Petitioner did not respond to the Department's request for additional documentation regarding which supplies were billed on the dates of service at issue.

the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding medical necessity.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the dates of service at issue based on medically accepted standards.

The IRO reviewer is a licensed physical therapist, actively practicing in the field of physical therapy. The IRO reviewer has knowledge in the care of injured persons involved in motor vehicle accidents and receive durable medical equipment rendered under the procedure code at issue. 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 Physical Medicine 2021 Magellan Clinical Guidelines for Medical Necessity Review and medical journals for its recommendation.

The IRO reviewer opined that the durable medical equipment at issue was not medically necessary and was overutilized in relation to the injured person's clinical scenario. The IRO reviewer explained that the injured person was prescribed a "pulse oximeter monitoring as needed while sleeping." However, the IRO reviewer opined that the Petitioner's request for a pulse oximeter probe was "outside the normal range of medical need for [the injured person's] level of function and subsequent oxygen saturation." The IRO reviewer further explained:

> Due to [the injured person's] immobility, a complex probe, such as the one provided in this scenario, is not indicated. In addition, there were no changes in [the injured person's] ventilator or oxygen status that supports the need for this type of oxygen probe.

The IRO reviewer further explained:

> According to Physical Medicine Guidelines from Magellan, DME and services are medically necessary when the clinical records clearly establish the medical need for the DME, and lesser or alternative options have been ruled out.

Based on the submitted documentation, the IRO reviewer noted that there were "no salient or sufficient reasons given to support why [the injured person] would need this exact type of oxygen probe." The IRO reviewer opined that "the type of oximeter probe requested is not medically necessary for [the injured person] given her functional status and current diagnosis."

Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the oxygen probe for use with an oximeter device provided to the injured person on July 2, 2021 was not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determination dated July 22, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

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