STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Rainbow Rehabilitation Centers, Inc
Petitioner **File No. 21-1025**

v

Farm Bureau Insurance Company
Respondent

Issued and entered
this 29th day of June 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 23, 2021, Rainbow Rehabilitation Centers, Inc (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 appeal concerns a bill denied by Farm Bureau Insurance Company (Respondent) for chiropractic treatments rendered by the Petitioner.

The Department accepted the request for appeal on May 7, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on May 11, 2021 and the Respondent received a copy of the Petitioner's submitted documents. The Respondent did not provide a reply to the Petitioner's appeal.

The Department assigned an independent review organization (IRO) to review the issues in this appeal and provide a report and recommendation to the Department. The IRO submitted its report to the Department on June 21, 2021.

The Petitioner's appeal is made under R 500.65, which allows a provider to appeal to the Department from the denial of a provider's bill. Accordingly, the denial constitutes a determination from which a provider may file and appeal to the Department. The Petitioner seeks payment in full for the dates of service at issue.

II. FACTUAL BACKGROUND

The Petitioner appeals the denial of payment for treatment rendered on December 2, 3, 7, 8, and 10, 2020 under current procedural terminology (CPT) codes 97537 and 99199 for community/work reintegration

and special service/procedure/report, respectively. On January 4, 2021, the Respondent issued an *Explanation of No-Fault Health Care Reimbursement* letter denying payment for the procedure codes at issue on the basis that the treatments should not be billed separately from the daily rate. The Respondent did not request a written explanation from the Petitioner regarding the medical necessity for the treatments at issue.

The Petitioner provided the Department with the injured person's medical record for the date of service at issue, schedule of fees for procedures, and the claim form submitted to the Respondent.

Petitioner's Argument

In its appeal request, the Petitioner argues that the treatment provided to the injured person under procedure codes 97537 and 99199 was not included in any other procedure and are classified as an "individual service." The Petitioner goes on to state that individual services are not subject to the per diem rate and are listed as a "Fee for Service" which was provided to the Respondent.

Respondent's Argument

In its Explanation of Review, the Respondent states that the treatment under codes 97537 and 99199 were denied because the "procedure should not be billed separately as it is included in the daily rate."

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that a 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 issues of medical necessity and inappropriate treatment.

In support of its argument, the Petitioner provided a treatment plan prescription for the injured person, respiratory therapy notes, vocational therapy notes, and fee schedule outlining included residential services and "fee for service" services. The Petitioner's treatment plan prescription notes that the injured person is diagnosed with unspecified intracranial injury with loss of consciousness of unspecified duration, sequela, quadriplegia, C5-7 complete, and other abnormal involuntary movements as the result of trauma sustained in a February 1991 accident.

The injured person received services in the Petitioner's facility which included young adult day program and counseling. The Petitioner's treatment notes for respiratory therapy, billed under procedure code 99199 on December 8, 2021, indicate that staff wiped down the injured person's "cough assist" and ordered missing equipment for the injured person. The Petitioner's vocational therapy treatment notes for December 2, 3, 7, and 10, 2021, billed under procedure code 97537, state the injured person worked on typing skills and use of a word processor.

In a letter included in its appeal request, the Petitioner explains that the treatments rendered under procedure code 97537 on December 2, 3, 7, and 10, 2020 are not included in the daily rate for services provided at the facility. Additionally, the Petitioner states in the same letter that treatment rendered under procedure code 99199 on December 8, 2020 was not included in the daily rate for services provided at the facility. In its Explanation of Review, the Respondent stated that procedure codes 97537 and 99199 should not be billed separately on the dates of service at issue. Accordingly, the Respondent denied the procedure codes as they are included in the daily rate for services.

The Director assigned an IRO to review the case file. The IRO reviewers included a board-certified physical medicine and rehabilitation physician with more than 25 years in practice, a coding consultant, and a licensed attorney (IRO reviewer). In its June 21, 2021 report, the IRO reviewer concluded that based on the submitted documentation, medical necessity was not supported for the dates of service at issue, in accordance with medically accepted standards as defined by R 500.61(i).

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 peer-reviewed journal articles supporting current evidence-based practice guidelines, including *Vocational rehabilitation process and work life*.

The IRO reviewer concluded that based on the documentation provided the use of procedure codes 99199 on December 8, 2020 and 97537 between December 2 and 10, 2020 were not medically necessary in accordance with medically accepted standards.

The IRO reviewer stated that the Petitioner's vocational therapy treatment notes did not establish medical necessity use of procedure code 97537. Specifically, the IRO reviewer stated that:

> ...an overall vocational rehabilitation assessment, to include the long-term goals of this therapy, and an assessment of present and future vocational and rehabilitation potential, was not documented, as is appropriate for this type of intervention...[That there is no documentation provided in this case supporting that these skills were necessary for this injured person for any clinical purpose.

The IRO reviewer stated that procedure code 97537 billed on December 7, 2020 was the only separate and distinct service rendered outside of the daily rate, as the service was the only procedure code submitted for reimbursement on that day. However, the IRO reviewer opined that the Petitioner's vocational therapy treatment notes for December 7, 2020 indicated the treatment was not medically necessary. The IRO reviewer stated that:

> ...[T]hat the documentation provided in this case does not show that these services were done at different times or that they were separate from one another, except for

> the 12/7/20 date of service as this was the only service billed on that date...[A]lthough eligible for billing, the documentation provided, however, does not establish that these services in question that were delivered at the facility were medically necessary.

Further, The IRO reviewer opined that the Petitioner's treatment note dated December 8, 2020 did not substantiate the use of procedure code 99199 as a "fee for service." Specifically, the IRO reviewer stated:

> The injured person's Cough Assist device was "wiped down." The consultant noted that no further details related to this cleaning activity was documented, including the circumstances that caused the need for the cleaning activity... [T]hese services were maintenance work for a device, at least part of which was due to a reported inability on the part of the staff to find the injured person's supplies. ...[T]hese were routine device maintenance activities, not clinical activities or medical services. ...[T]he services that were performed were not eligible for billing under CPT code 99199 and are included in a global charge for facility care.

The IRO reviewer concluded that while the Petitioner's use of procedure code 97537 is eligible for billing outside of the daily rate, the treatment notes do not support medical necessity for the treatments rendered between December 2 and 10, 2020. Additionally, the IRO reviewer indicated that the Petitioner's use of procedure code 99199 for device maintenance work is not permitted under medical guidelines as defined in R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determination dated January 4, 2021.

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:

Recoverable Signature

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford