STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

NeuroRestorative Michigan
Petitioner **File No. 21-1036**

v

Allstate Insurance Company
Respondent

Issued and entered
this 30th day of June 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On May 10, 2021, NeuroRestorative Michigan (Petitioner) filed with the Director of the Department of Insurance and Financial Services (Department) a request for 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 Allstate Insurance Company (Respondent) for the Petitioner's telephone assessment and travel to the home of the injured person for services on February 12, 2021.

The Department accepted the request for appeal on May 10, 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 19, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent filed a reply to the appeal on June 4, 2021.

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 25, 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 an appeal to the Department.

II. Factual Background

The Petitioner appeals the denial of payment for telephone services and travel related to a home therapy visit rendered to the injured person on February 12, 2021. The services involved the Petitioner troubleshooting issues with an electrical stimulation device utilized by the injured person for pain relief.

On May 3, 2021, the Respondent issued an Explanation of Medical Bill (EMB) denying payment as not medically necessary for Current Procedural Terminology (CPT) codes 98967 and 99082, non-physician telephone services and unusual provider travel to facilitate care, respectively. The codes were billed under a place of service code 12 (denoting that the services were provided at the injured person's home) but were in fact performed at home and via telephone. The Respondent noted in its EMB that the billed services were delivered under an outpatient physical therapy plan of care and were modified accordingly. Through its EMB, the Respondent requested a statement of medical necessity and supporting documentation from the Petitioner, but the Respondent indicated no response was received.

Petitioner's Argument:

In a letter to the Department included with its appeal documentation, the Petitioner argued that the billed telephone services and travel to the injured person's home were recommended by the injured person's doctor as medically necessary.

Respondent's Argument:

The Respondent denied payment of the billed services (CPT codes 98967 and 99082) as not meeting standards of medical necessity and that they should have been included with the residential per diem rate.

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 is a matter of medical necessity and appropriate billing and coding.

In support of its position, the Petitioner submitted physical therapy notes dated February 12, 2021, which indicate that the Petitioner provided electrical stimulation treatment to the injured person for pain relief. The medical record indicates that the billed procedure codes at issue concerning this date of service were for telephone services, including assessment and management of the injured person's care, and round-trip travel time for a home visit. The medical record states that the Petitioner communicated by telephone with the durable medical equipment (DME) provider to facilitate management of the equipment

necessary for proper function of the electrical stimulation device, and the Petitioner also discussed future treatment with the injured person.

In its May 3, 2021 EMB, the Respondent stated that the services did not meet standards of medical necessity and that they were delivered under an outpatient physical therapy plan of care. In its reply, the Respondent stated that it paid for the electrical stimulation treatment on the date of service at issue but denied the CPT codes at issue, 98967 for the telephone services and 99082 for unusual travel, indicating that "these two services would be considered part of the per diem rate." The Respondent further noted that its staff attempted to contact the Petitioner for further clarification regarding the unpaid procedure codes and the request for additional information but did not receive a response.

The Director assigned an IRO to review the case file. In its June 25, 2021 report, the IRO reviewer recommended that the Department reverse the insurer's denial regarding payment of the telephone services. However, the IRO reviewer recommended that the Department uphold the insurer's denial of payment of usual travel relating to the date of service at issue.

The IRO reviewer is board-certified in neurology and is in active practice. The IRO reviewer referenced R 500.61(i), in its report, 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, boards, and associations. In reaching its recommendation, the IRO reviewer relied on the Centers for Medicare and Medicaid Services National Coverage Determination (NCD) for Neuromuscular Electrical Stimulation and Centers for Medicare and Medicaid Services standards relating to TENS units for chronic pain.

In its report, the IRO reviewer concluded that the telephone service, billed as code 98967 and conducted on the date of service at issue, was medically necessary and was provided in accordance with medically accepted standards as defined by R 500.61(i). The IRO reviewer explained that the medical record showed that the injured person reported his transcutaneous electrical nerve stimulation (TENS) unit was not working correctly as the gel surfaces of the electrodes were dried out and the lead wires were worn. The medical record stated that the Petitioner assisted by telephone to educate the injured person on electrode care and how to keep the unit working properly.

The IRO reviewer recommended that the Department reverse the Respondent's determination regarding inclusion of the Petitioner's telephone services in the per diem rate, explaining in its report that "code 98967 would not be considered part of the per diem rate as it was for a service outside of the intended purpose of the physical therapist."

Although the IRO reviewer recommended that the telephone service provided on the date of service at issue should be paid, the IRO reviewer affirmed the Respondent's denial of payment regarding

the services billed under CPT code 99082 for unusual travel, stating that this procedure code was not medically necessary and could be considered a duplicate charge.

The IRO reviewer further explained:

> Code 99082 is for unusual travel. This would include when a provider travels to facilitate patient care in a way not normally required, such as accompanying a patient in an ambulance or medical flight. However, this service would be considered part of the per diem rate. As such, code 99082 would be a duplicate charge.

The IRO reviewer concluded that the telephone service (code 98967) provided by the Petitioner on February 12, 2021 was medically necessary and in accordance with medically accepted standards, as defined by R 500.61(i). However, the IRO reviewer concluded that the unusual travel utilized to facilitate treatment (code 99082) was not medically necessary because it was a duplicate charge.

IV. ORDER

The Director upholds the Respondent's determination for CPT code 99082. The Director reverses Respondent's May 3, 2021 determination for CPT code 98967 and orders Respondent to reimburse Petitioner in the amount of $50.00, plus interest as provided under MCL 500.3142 and R 500.65(6). Respondent shall, within 7 days of the date of this order, submit proof that it has complied with 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:

Recoverable Signature

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford