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. 21-1051**

v

Frankenmuth Mutual Insurance Company
Respondent

Issued and entered
this 14th day of July 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On May 25, 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 Frankenmuth Mutual Insurance Company (Respondent) for therapy treatments rendered by the Petitioner on six dates of service in February 2021.

The Department accepted the request for appeal on May 25, 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 26, 2021, and sent the Respondent a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on June 16, 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 28, 2021.

The Petitioner's appeal is made under R 500.64(3), which allows a provider to appeal to the Department from an insurer's denial of a bill. The Petitioner seeks payment in the full amount billed to the Respondent.

II. Factual Background

The Petitioner appeals the denial of payment for physical therapy rendered on the following dates of service: February 3, 13, 19, 22, 24, and 26, 2021. On April 13, 2021, the Respondent issued an Explanation of Review (EOR) to the Petitioner, denying the Petitioner's billed claim for treatment rendered as not medically necessary and overutilized in accordance with medically accepted standards.[1] In its EOR, the Respondent noted it would review any additional records if submitted by Petitioner regarding the billed services.

With its appeal request, the Petitioner submitted supporting documentation regarding the medical necessity of physical therapy for the dates of service at issue, including chart notes and a statement from the injured person's treating pain specialists. The supporting documentation associated the billed treatment to the following diagnoses: intracranial injury without loss of consciousness, trochanteric bursitis of hip, thoracic pain, and low back pain. In addition to those diagnoses, according to the Petitioner's submitted medical documentation, the injured person also received therapeutic treatment for pain in the left arm. The procedure codes billed for the dates of service at issue were 97140, 97110, 97530, and 97750, corresponding to manual therapy, therapeutic exercise, functional performance activities, and physical performance testing, respectively.

Petitioner's Argument:

In its appeal, the Petitioner argues that the services provided to the injured person on the dates of service at issue were medically necessary to treat the injured person's diagnoses, to improve daily function, and improve mobility for safe transfers.

Respondent's Argument:

Based on its EOR, the Respondent denied payment for the services provided as not medically necessary and not in accordance with medically accepted standards defined by the Official Disability Guidelines.

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] The Respondent's EOR also stated that the physical performance testing (procedure code 97750) was reimbursed at the usual and customary amount for the geographical area and using the Fair Health Charge Benchmark Database based on the provider's geographic area. However, the record shows that all denials were on the basis of medical necessity.

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 overutilization.

In support of its position, the Petitioner submitted a letter dated May 24, 2021, written by the injured person's pain specialists, which stated that physical therapy was warranted to improve function in relation to the diagnoses of trochanteric bursitis, thoracic and low back pain, and left arm pain. The pain specialists' letter stated that physical therapy was necessary to address "goals of easier transfers, standing up, walking, and working on safety," and noted that the injured person was improving in these areas with physical therapy.

The Petitioner also submitted medical documentation for the dates of service at issue indicating complaints of continued pain in the right hip and left shoulder with therapy addressing range of motion, strengthening, and safe transfers.[2] The therapy visits on February 22, 24, and 26, 2021 indicated improved strength and mobility with transfers. The medical records for these visits indicated difficulty with tactile and verbal cues for exercise techniques and increased pain in the right leg with exercises. According to the medical records, the injured person's care plan at these visits was to continue therapy 2-3 times a week as tolerated to improve range of motion and transfer safety.

Explaining its determination, the Respondent stated that the Official Disability Guidelines allow for "fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical therapy." The Respondent also noted that the injured person had completed 23 sessions of physical therapy prior to the submitted dates and that additional visits were outside the recommended treatment guidelines and not supported by the medical records. The Petitioner's submitted documentation did not include records relating to prior therapy treatment received.

The Director assigned an IRO to review the case file. In its June 28, 2021 report, the IRO reviewer recommended that the Department uphold the Respondent's determination to deny payment for the dates of service at issue as the treatments were not medically necessary and were not in accordance with medically accepted standards as defined by R 500.61(i).

The IRO reviewer is board-certified in physical medicine and rehabilitation and is in active practice. 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, boards, and associations. The IRO reviewer relied on the Official Disability Guidelines (ODG) in support of its recommendation.

---

[2] The Petitioner's submitted medical documentation for her February 2021 therapy visits also noted a recent hospitalization for a transient ischemic attack (TIA) with related complaints of fogginess, weakness, and inability to do her home exercise program for a period of time.

The IRO reviewer pointed to a lack of medical documentation to support the medical necessity of treatment and explained that the submitted documentation did not provide specific reasoning for the injured person to resume in-person physical therapy after a long period of time had passed since her initial injury.[3] The IRO reviewer concluded that the therapeutic services for the dates of service at issue were not appropriate for the injured person's accident-related diagnoses.

The IRO reviewer further noted that the Petitioner's medical records did not state a clear duration of the injured person's treatment plan. While the medical documentation showed a plan of care for 2-3 times a week as tolerated to improve range of motion and transfer safety, the documentation did not reference a specific duration. The IRO reviewer concluded the following:

> More than 8 years after injury, the [injured person] would be expected to have received maximum potential benefit from formal therapeutic treatment. The therapeutic services provided are not considered to be medically necessary per medically accepted standards and, thus, overutilized in frequency/duration.

The IRO reviewer also stated in the report that the submitted documentation failed to detail any significant medical history of the injured person or to address concerns about her deterioration or any new injury which would warrant the need for treatment. Specifically, the IRO reviewer stated the following:

> Physician progress notes or other documentation should be provided detailing exactly when (or return to) in-person therapy was initially provided, as well as when and why therapy was stopped. There should be documentation of the exact medical reasoning for the resumption of treatment (either a new injury or detailed information regarding deterioration and the believed etiology for that deterioration).

Based on a review of the submitted documentation, the IRO reviewer concluded that "there is not enough support to make the determination that the therapeutic services on the [dates of service at issue] were medically necessary."

The IRO reviewer recommended that the Director uphold the Respondent's determination on the basis that the physical therapy treatments provided to the injured person on the dates of service at issue were not medically necessary, were not in accordance with medically accepted standards, as defined by R 500.61(i), and were overutilized in duration compared with such standards.

IV. ORDER

The Director upholds Respondent's determination dated April 13, 2021.

---

[3] The medical records indicate that the injured person also received telehealth therapy during some of the dates of service at issue due to COVID-19 safety concerns.

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