STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Hulst Jepsen PT
Petitioner **File No. 21-1053**

v

Citizens Insurance Company of the Midwest
Respondent

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

ORDER

I. PROCEDURAL BACKGROUND

On May 26, 2021, Hulst Jepsen PT (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 determinations from Citizens Insurance Company of the Midwest (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatments under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Department accepted the request for appeal on June 8, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on June 8, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on June 22, 2021.

The Department assigned an independent review organization (IRO) to analyze issues requiring medical knowledge or expertise relevant to this appeal and provide a report and recommendation to the Department. The IRO submitted its report to the Department on July 13, 2021, providing a recommendation to the Department on the issues in this appeal.

The Respondent issued the Petitioner ten written notices of the Respondent's determination under R 500.64(1) in April and May of 2021. The Petitioner seeks payment in the full amount billed for the dates of service at issue.

II. FACTUAL BACKGROUND

The Petitioner appeals the denial of payment for physical therapy treatments rendered on March 17, 22, 24, 26, and 31 and April 6, 9, 15, 20, and 27 of 2021, under current procedural terminology (CPT) codes 97110, 97140, 97112, and 97530. The Respondent issued 10 determinations: one on April 9, 2021, one on April 12, 2021, four on April 29, 2021, three on May 9, 2021, and one on May 24, 2021, all of which denied the physical therapy treatments on the basis that the treatments were not medically necessary.

For two of the ten determinations, the Respondent requested written documentation from the Petitioner pursuant to R 500.63, seeking initial exam documents from the referring provider to establish the injured person's diagnosis. There is no documentation in the case file that the Petitioner responded to the Respondent's request within the required 30 days.

In the other eight determinations supporting its denials, the Respondent asserted that the Petitioner's "documentation suggests a failure to meet general accepted medical standards and standard professional treatment protocols."

In its appeal request, the Petitioner argues that physical therapy treatments provided to the injured person under procedure codes 97110, 97112, 97140, and 97530 on the ten dates of service at issue were medically necessary. In support of its position, the Petitioner submitted documentation, including daily notes for the dates of service at issue, treatment notes from a referring physician, a physical therapy referral prescription, and letter in support of its position. The treatment notes from a referring physician dated February 15, 2021, stated that the injured person was diagnosed with cervical spondylosis without myelopathy and cervicalgia due to a motor vehicle accident which occurred on January 18, 2020. The Petitioner's supporting documentation demonstrated chief complaints from the injured person that included neck pain, decreased cervical range of motion, decreased activities of daily living and work function, and post-concussion symptoms. Further, the Petitioner argues that the physical therapy treatments, which includes dry needling, manual therapy, and speech therapy, has resulted in a 50% improvement in the injured person's function.

In its reply, the Respondent reaffirmed its position that procedure codes 97140, 97112, 97110, and 97530 were not medically necessary on the dates of service at issue. Further, the Respondent argues that the Petitioner's submitted documentation lacked objective evidence of the injured person's improvement to justify continued therapy, and there was no repeat prescription of continued therapy.

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 overutilization of treatment.

The Director assigned an IRO to review the case file. The IRO reviewer is a licensed physical therapist with an active clinical practice of 27 years. In its July 13, 2021 report, the IRO reviewer opined that the documentation submitted failed to establish medical necessity for the physical therapy treatments rendered and that the treatments were overutilized in frequency and duration for the dates of service at issue in accordance with medically accepted standards.

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 Official Disability Guidelines (ODG), and American Physical Therapy Association (APTA) guidelines.

The IRO reviewer summarized its recommendation as follows:

> The Official Disability Guidelines (ODG) recommend up to 9 physical therapy visits in 8 weeks for treatment of cervicalgia. [The injured person] in this episode of care had at least 24 physical therapy visits in 10 weeks, far exceeding the recommended number of visits from the ODG.

Specifically, the IRO reviewer noted that the submitted documentation was not sufficient to justify medical necessity:

> ODG state that patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction prior to continuing with physical therapy, however, there were no assessment[s] performed at any of the physical therapy visits rendered on 3/17/2021, 3/24/2021, 3/26/2021, 3/31/2021, 4/6/2021, 4/15/2021, 4/20/2021, and 4/27/2021. None of these clinical notes included any measurable data on subjective findings… objective findings… or any functional findings. None of these clinical notes demonstrated if the [injured person] was moving in a positive direction, no direction or a negative direction as the result of skilled physical therapy intervention.
>
> [W]hen treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. There were no exceptional factors noted in the clinicals submitted for review which would support the medical necessity of visits[.]

The IRO reviewer also noted that the documentation did not demonstrate compliance with APTA standards. Specifically, the IRO reviewer stated:

> There is no initial evaluation submitted for review. [A] physical therapist examination must be documented, dated, and appropriated authenticated by the physical therapist that performed it.
>
> There is an incomplete plan of care in the records submitted for review. [T]he plan of care must be based on the examination, evaluation, diagnosis, and prognosis of the evaluation, identify anticipated goals and expected outcomes, stated in measurable terms. It must also describe the proposed intervention program, including frequency and duration and include documentation that is dated and appropriately authenticated by the physical therapist that establish the plan of case. Goals were listed at each daily note, with a corresponding percentage point representing level at which the goal was met, however without any supporting data in the records.
>
> There is no re-evaluation in the records. [T]he therapist must re-examine the [injured person] as necessary during an episode of care to evaluate the progress or change, update the [injured person]'s status, including goals and outcomes and modify the plan of care and intervention program accordingly.

Further, the IRO reviewer opined that the physical therapy treatments rendered on the dates of service at issue were overutilized in frequency and duration in accordance with medically accepted standards. The IRO reviewer explained:

> The Official Disability Guidelines (ODG) recommend up to 9 physical therapy visits in 8 weeks for the treatment of cervicalgia. The [injured person] in this episode of care had at least 24 physical therapy visits in 10 weeks, far exceeding the recommended number of visits from the ODG. The ODG recommend a treatment frequency of up to 3 times per week initially, with emphasis on active treatments, and self-directed home therapy, to an eventual decrease treatment frequency to 1 time per week or less; however, the [injured person] continued to be treated at a high frequency of 2-3 times per week.

The IRO reviewer concluded that the physical therapy treatment provided to the injured person on the dates of service at issue was not medically necessary and was overutilized in frequency and duration in accordance with medically accepted standards, as defined by R 500.61(i). Accordingly, the Director upholds the Respondent's determinations concerning the dates of service at issue.

IV. ORDER

The Director upholds the Respondent's ten determinations issued on April 12 and 29 and May 9 and 24, 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