STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

HQ Inc.
Petitioner **File No. 21-1057**

v

Esurance Property and Casualty Insurance Company
Respondent

Issued and entered
this 23rd day of July, 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 2, 2021, HQ Inc. (Petitioner) filed with the Director of 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 Esurance Property and Casualty Company (Respondent) that Petitioner overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Respondent issued the Petitioner a written notice of determination under R 500.64(1) on April 27, 2021, and attached an Explanation of Benefits (EOB) for each billed date of service. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on June 2, 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 7, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent did not file a reply to the appeal.

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 to the Department on July 12, 2021, providing a recommendation to the Department on the issues in this appeal.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on April 6, 15, 20, 21, and 22, 2021. The Current Procedural Terminology (CPT) codes billed were 97110, 97112, 97530, 97140, 97535 with modifier 59, and 97162. These codes relate to therapeutic exercises, neuromuscular education, functional performance activities, manual therapy, home management training, and physical therapy evaluation, respectively.

With its appeal request, the Petitioner submitted medical documentation indicating the diagnoses of bilateral hip joint pain and generalized muscle weakness. The Petitioner's medical records also noted a previous right hip surgery and a possible labral tear of the left hip joint. The medical documentation included an April 22, 2021 care plan for therapy 2 times per week for 4 weeks. The Petitioner also submitted a copy of the Respondent's April 27, 2021 determination letter and two EOB statements relating to the dates of service at issue. The Respondent did not request an explanation from Petitioner regarding the necessity or indication for the treatment received, pursuant to R 500.63.

The Petitioner's request for an appeal included a statement from a treating physical therapist, stating the following:

> [The injured person] has seen progress in all measurements of ROM, strength and function since IE (initial evaluation) per healing times and protocol. Although there is improvement, continued pain and limitation remain…Treatment has focused on managing his symptoms and helping [the injured person] maintain his functional status.

The Respondent's EOBs for the dates of service at issue stated the following:

> Treatment exceeded the estimated timeframe for recovery from injury, per Milliman Care Guidelines. Number of visits exceeded comparable claims according to data compiled by Milliman Care Guidelines. If rehabilitation potential is insignificant in relation to the duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary per CMS guidelines. Justification for treatment must include evidence of attainable improvement in a reasonable and generally predictable time period per CMS guidelines. If at any point it is determined loss of function is easily reversible or treatment is not rehabilitative, the services will no longer be considered reasonable and necessary per CMS guidelines.

The Respondent did not provide the Department with a reply to Petitioner's appeal or other documentation in support of its determination.

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 overutilization of treatment.

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 and the treatment was overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is a medical doctor board certified in physical medicine and rehabilitation and pain medicine. The IRO reviewer maintains an active practice at a regional pain and spine institute. 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, board, and associations. The IRO relied on journal articles regarding physical therapy protocols following hip arthroscopy for impingement and labral repair and regarding outcomes after arthroscopic surgery compared to physical therapy for femoracetabular impingement. The IRO reviewer also relied on Official Disability Guidelines.

The IRO reviewer opined that the physical therapy services provided to the injured person on the dates of service at issue were not medically necessary in accordance with medically accepted standards as defined by R 500.61(i). The IRO reviewer referenced ODG by Milliman Care Guidelines (MCG) as follows:

> [ODG] allow for fading of treatment frequency (from up to 3 visits per week to 1 or less)…In addition, active self-directed home physical therapy may include the following simple hip-strengthening exercises…Labral tear: 9 visits over 8 weeks, post-surgical (arthroscopic) 9 visits over 8 weeks.

The IRO reviewer further noted that the injured person had a prior labral repair surgery in September 2020 and stated that it was unknown how many physical therapy sessions he had following that surgery and before the dates of service relevant to this appeal.

The IRO reviewer explained that the medical documentation for the dates of service at issue indicated the injured person was performing exercises correctly with verbal cues only and progressing toward treatment goals. Further the IRO reviewer noted that the April 20, 2021 discharge summary showed minimal improvements, but that the injured person was able to do the therapy exercises independently. The

IRO reviewer noted that the injured person continued to receive the same form of additional physical therapy treatments after he was discharged from therapy.

The IRO reviewer concluded:

> [The injured person] is receiving an excessive amount of passive modalities without evidence of significant objective gains and this treatment would not be considered medically necessary, standard of care or in accordance with medically accepted standards as defined by R 500.61(i).

Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the treatments provided to the injured person on April 6, 15, 20, 21, and 22, 2021 were not medically necessary and were overutilized in frequency or duration in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determination dated April 27, 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:

7/23/2021

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford