STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Scott B. Silver
Petitioner **File No. 21-1069**

v

Allstate Property and Casualty Insurance Company
Respondent

Issued and entered
this 22nd day of July 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 18, 2021, Scott B. Silver (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 an appeal concerns the denial of a bill by Allstate Property and Casualty Insurance Company (Respondent) on the basis 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 Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Petitioner now seeks payment in the full amount billed for the date of service at issue.

The Department accepted the request for appeal on June 18, 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 18, 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 28, 2021.

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

The Petitioner appeals the denial of payment for in-person case management services and costs associated with travel from Michigan to Florida on April 9, 2021, under procedure code T2022. On May 26, 2021, the Respondent denied the Petitioner's bill for five lines of service under procedure code T2022, which included in-person case management services and travel expenses for the date of service at issue. The Respondent did not request a written explanation from the Petitioner.

In its appeal request, the Petitioner argues that it should be reimbursed for the in-person meeting and services provided on April 9, 2021, as well as travel expenses incurred. The Petitioner asserts that on-site meetings with the injured person in a residential program is a reasonable and customary practice. The Petitioner further states that this is the first time the Respondent has denied payment for such services.

In support of its argument, the Petitioner submitted supporting documentation, including two progress reports dated prior to the in-person meeting and following the in-person meeting. The Petitioner's supporting documentation also included two order requisitions outlining the type of services the injured person was to receive and a letter in support of its position. The Petitioner's order requisition notes stated that the injured person was diagnosed with unspecified intracranial injury with loss of consciousness of an unspecified duration due to an October 1987 motor vehicle accident. Based on an April 2021 prescribed order requisition, the injured person was receiving vocational therapy, recreational therapy, and psychotherapy at a residential care facility in Florida. The Petitioner states that it has been providing case management services to the injured person since 1987.

In a progress report dated December 20, 2020, the Petitioner recommended meeting with the injured person at the residential care facility in Florida to follow through on residential programming. The progress report indicated that the Petitioner would bill for "2 to 3 professional hours" and "10 to 11 travel/wait hours" to account for travel time and expenses for the out-of-state, in-person meeting.

On a subsequent progress report dated April 12, 2021, the Petitioner noted that he had been in communication with the injured person, members at the residential program facility, including the program director, activities staff, and a social worker via video conference and telecommunication several times prior to the Petitioner's in-person meeting in Florida. The purpose of the communications was to discuss the progress and case management of the injured person. In addition, the progress report noted that the Petitioner's meeting at the Florida residential program facility was attended by an activity staff member, program director, social worker, injured person, and the Petitioner. The Petitioner states that there has been a consistent history of these meetings for 10 years, and this is the first time the Respondent has denied reimbursement.

In its reply, the Respondent reaffirmed its denial stating that "[t]here is no reasonable or necessary rationale for [the Petitioner] to fly to Florida for one day to have a face-to-face meeting. Prior communication has successfully taken place utilizing video conferencing and/or telephone for well over a year."

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.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer opined that the documentation submitted failed to establish medical necessity for the in-person case management services and travel expenses in accordance with medically accepted standards as defined by R 500.61(i).

The IRO reviewer is a practicing rehabilitation counselor and has been certified in forensic vocational rehabilitation for 7 years. 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 generally accepted guidelines and peer-reviewed journal articles supporting current evidence-based practice guidelines, including Medical Case Management Guidelines.

The IRO reviewer opined that the in-person case management services provided to the injured person on April 9, 2021, were not medically necessary in accordance with medically accepted guidelines:

> [The Petitioner]'s reports and the treating physician's order do not provide clinical rationale that would require the [Petitioner]… to travel to Florida for one-day face-to-face staffing.

Specifically, the IRO reviewer noted the following:

> Considering that [the Petitioner] provided telehealth case management to the injured person for over a year, medical rationale should have been outlined to the carrier, with a written response from the carrier, prior to [the Petitioner] traveling for an on-site, face-to-face meeting.
>
> [The Petitioner]'s report does not indicate that [it] provided medically necessary case management or a vocational service which required [its] onsite presence on 4/9/21. As a result, the travel is not medically necessary because the services provided could have been effectively conducted telephonically or through telehealth as they had been conducted for the past year.

The IRO reviewer also noted that the documentation did not substantiate the need for an in-person meeting for case management services, especially during a pandemic:

> The date of service, 4/9/202[1], falls within the Global Pandemic time frame.
>
> [D]uring the Global pandemic, most vocational and case management services have been, and continue to be provided via telehealth appointments.

Further, the IRO reviewer opined that the medical documentation provided did not substantiate the use of procedure code T2022 for case management services and travel expenses on April 9, 2021. The IRO reviewer explained:

> [The Petitioner] used code T2022 appropriately to bill for the provision of case management services provided on 4/9/21 as prescribed by the claimant's physician. However, there was no medical necessity or clinical rationale documented to provide these services on-site nor was service provided that required [the Petitioner]'s presence on-site. It has also been documented by [the Petitioner] and the [Respondent] that [the Petitioner] has provided case management services to this claimant effectively and successfully via telehealth for over a year thus funding was not validated by the [Respondent].

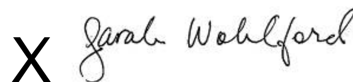
Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the in-person case management services and travel expenses provided to the injured person on April 9, 2021, were not medically necessary in accordance with medically accepted standards, as defined by R 500.61(i).

IV. Order

The Director upholds the Respondent's determination dated May 26, 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:



Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford