STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Rehab Without Walls Inc
Petitioner **File No. 21-1100**

v

Allstate Insurance Company
Respondent

Issued and entered
this 5th day of August 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On June 26, 2021, Rehab Without Walls, 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 Allstate Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment or that the cost of the treatment was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Respondent issued the Petitioner written notices of the Respondent's determination under R 500.64(1) on May 6 and May 10, 2021. Petitioner now seeks reimbursement in the amount of $701.50, which is the outstanding balance for the dates of service at issue.

The Department accepted the request for an appeal on July 6, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on July 6, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on July 8, 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 and recommendation to the Department on July 22, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for physical therapy treatments rendered on December 15 and 22, 2020, billed under revenue code 0422 for hourly physical therapy and diagnosis code S14.1095, which represents an unspecified injury.

With its appeal request, the Petitioner submitted handwritten treatment notes for the dates of service at issue. The medical record for December 15, 2020 noted that the Petitioner provided the injured person with a home exercise program for the upper extremities and training for an app-based smart garage door opener. The medical record for December 22, 2020 noted that the Petitioner provided assistance with "standing tolerance and outdoor mobility" at a local mall and also that the injured person had difficulty with gripping.

The Petitioner's request for an appeal stated that on December 15, 2020, in addition to helping the injured person with using the garage door opener, they "helped the patient use her exerciser, her resistance band and TENS unit." The Petitioner billed the Respondent for 1.75 units of physical therapy for December 15 and 2 units for December 22, 2020. The Petitioner's submitted documentation included two bills marked "reconsideration" for the dates of service at issue and noted unspecified diagnosis codes.

On January 14, 2021, the Respondent requested an explanation from the Petitioner regarding the necessity or indication for the treatment rendered and requested legible progress notes and a specific diagnosis, pursuant to R 500.63. The Respondent stated in its reply that it did not receive the requested information.

On May 10, 2021, the Respondent issued an explanation of payment (EOP) for the treatment rendered on December 15, 2020, in which it agreed to pay for 1 hour of physical therapy but denied payment for the second hour. In its EOP, the Respondent reasoned that it did not owe for equipment training because the training was a duplicate service paid to another provider. The Respondent issued an EOP dated May 6, 2021 for the December 22, 2020 treatment in which it noted a coding discrepancy for the type of service provided as well as an unspecified diagnosis code.

In its reply, the Respondent reaffirmed its position, stating it denied payment for a portion of the first date of service at issue because "we don't owe for equipment training; this was a duplicate service that we have already paid to another provider."

Regarding the second date of service at issue, the Respondent stated the following in its reply:

> Provider is using a physical therapy code when they are performing community integration. The notes are illegible, we have requested legible records more than once. They are also utilizing an unspecified diagnosis code.

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.

The Director assigned an IRO to review the case file. In its report, the IRO reviewer concluded that, based on the submitted documentation, the "physical therapy treatments, equipment training, and community integration services provided to the injured person" on the dates of service at issue were not medically necessary in accordance with medically accepted standards.

The IRO reviewer is in active practice and is board-certified in physical medicine and rehabilitation and pain management. 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 reviewer relied on the American Physical Therapy Association's (APTA) Standard of Practice for Physical Therapy and peer-reviewed literature in physical therapy and pain management.

The IRO reviewer opined that the physical therapy services and equipment training provided to the injured person on December 15, 2020 were not billed appropriately. The IRO reviewer explained that the bill did not include valid procedure codes to support the services rendered, and it did not include documentation of time to support correct reporting of time increments. The IRO reviewer noted:

> Furthermore, the claim form reports an hourly physical therapy charge, submitted as a facility claim however, the services were not rendered in a facility setting. Therefore, the billing of a facility charge would not be appropriate.

The IRO reviewer stated that the "Petitioner's use of an unspecified diagnosis code on the dates of service at issue is not in accordance with generally accepted medical billing and coding practices." The IRO reviewer noted that the submitted medical documentation was not consistent with standard coding practices and APTA guidelines as it did not provide a specific diagnosis for the injured person to support the services rendered. The IRO reviewer further noted that the medical record provided is "partly illegible and does not include detail regarding the injury or condition, treatment plan, specified treatment region, goals, or response to therapy."

The IRO reviewer explained:

> While circumstances do exist that may warrant use of an unspecified diagnosis code, there is lack of clinical information provided for this case...In order to receive payment for services, the provider must establish medical necessity, thereby justifying care provided by presenting information to include signs, symptoms, or background facts describing the reason for care. In billing diagnosis codes help to describe this information. While the diagnosis code S14.109S represents an unspecified injury at unspecified level of cervical spinal cord, subsequent encounter, there is no mention of a spinal cord injury in the medical records; therefore, the diagnosis code is not supported.

The IRO further opined:

> There is no described area of treatment and no indication of injured person's diagnosis and current deficit. There is no indication of the injured person's current abilities, or activities of daily living. There are no noted goals of treatment and long-term plan/outcome...the [service] is not provided at a level that is consistent with best available evidence and current physical therapist practice.

Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the treatments and services provided to the injured person on December 15 and 22, 2020 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 determinations dated May 6 and May 10, 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