STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Onward Therapy Services
Petitioner

File No. 21-1130

v

Home-Owners Insurance Company
Respondent

Issued and entered
this 9th day of September 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On July 19, 2021, Onward Therapy Services (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 determination of Home-Owners Insurance Company (Respondent) that the Petitioner overutilized or otherwise rendered or ordered inappropriate treatment under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Respondent issued the Petitioner a written notice of the Respondent's determination under R 500.64(1) on July 14, 2021. 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 July 22, 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 22, 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 August 12, 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 August 20, 2021.

II. Factual Background

This appeal concerns the denial of payment for physical therapy treatments rendered on June 16 and 18, 2021. The Current Procedural Terminology (CPT) codes at issue are 97110 and 97140, which are described as therapeutic exercise and manual therapy.

With its appeal request, the Petitioner submitted medical records for the dates of service at issue, which identified the injured person's diagnoses as post-laminectomy syndrome and chronic pain due to trauma. The medical records indicated that, in relation to his condition, the injured person had decreased range of motion and strength, pain and impaired balance, and gait. The submitted documentation also included a letter from a treating physician stating that the injured person requires physical therapy to address the following additional problems related to the motor vehicle accident: chronic low back pain with radicular symptoms due to lumbar fractures and status post fusion, right rotator cuff tear status-post surgery with persistent partial frozen shoulder, left knee pain status post arthroscopy, traumatic brain injury, post-traumatic stress, vertigo, and right thumb ligament tear.

The Petitioner provided a statement with its supporting documentation stating that the injured person required the physical therapy treatments rendered on the dates of service at issue to improve mobility and to prevent deterioration of function. The Petitioner stated that the injured person "received skilled physical therapy" and that the injured person has had "significant improvement in low back and core strength as well as strength in the left lower extremity" following treatment. The Petitioner also explained that the injured person's right hip has worsened and that he has had increased pain in the right lower extremity, pain with managing stairs and sit to stand transfers.

The Petitioner's request for an appeal stated:

> The skilled therapy provided cannot be safely and effectively carried out by the [injured person] personally, or with the assistance of non-therapists, including unskilled caregivers due to: Lack of advanced collegiate education/skill set to provide exercise with the recommended intensity…to protect and prevent additional injuries…to assure safety while performing dynamic balance exercises…and to assess ambulation status regarding needed bracing, assistive devices, and safety.

The Petitioner stated that it relied on the American Physical Therapy Association practice guidelines, The Center for Medicare and Medicaid Services (CMS) coverage information, and the definition of "the practice of physical therapy" within the Michigan Public Health Code in support of medical necessity for the treatments rendered on the dates of service at issue.

It its reply, the Respondent explained that the physical therapy treatments were reviewed by a physical medicine and rehabilitation and pain management doctor, a medical doctor with chiropractic experience, and an occupational medicine doctor. The Respondent stated that these physicians found that the treatments on the dates of service at issue were "excessive" and not medically necessary. The Respondent stated that the Petitioner failed to provide justification for its argument that the injured person's caregivers cannot effectively

and safely carry out therapy services and that the Petitioner "has failed to submit sufficient evidence to warrant its excessive services."

In its reply, the Respondent reaffirmed its denial of the treatments on the dates of service at issue. It stated that it relied on the Official Disability Guidelines (ODG) for Physical/Occupational Therapy, the Counsel on Chiropractic Guidelines and Practice Parameters (CCGPP), and relevant medical studies. Furthermore, the Respondent noted that ODG Physical Therapy guidelines allow for fading of treatment frequency in relation to the injured person's conditions and stated that "the completed therapy sessions to date should have provided ample time to transition [the injured person] into a dynamic home exercise program to further address any ongoing deficits."

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.

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 treatments were overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is board-certified in physical medicine and rehabilitation and has an 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, board, and associations. The IRO reviewer relied on the American Board of Physical Medicine and Rehabilitation (ABPMR) and American Academy of Physical Medicine and Rehabilitation (AAPM&R) Endorsed or Affirmed Guidelines as well as evidence-based medical literature regarding rehabilitation and traumatic brain injury.

The IRO reviewer opined that the "clinical documentation does not support medical necessity as there is no documentation indicating significant changes from [physical therapy]." The IRO reviewer explained that the injured person's diagnoses were stable and that functional improvements were evident. The IRO reviewer further noted that the injured person received 77 physical therapy sessions for pain management of chronic low back pain with radicular symptoms. The IRO reviewer stated that during the June 18, 2021 therapy session, the injured person reported "improved posture with gait and less antalgic gait pattern," less catching through the right hip, and reduced pain while standing. The IRO reviewer noted the injured person continued to use medications to treat his chronic low back pain while receiving physical therapy.

The IRO reviewer opined:

> Recommended frequency of physical therapy based on the Physical Medicine and Rehabilitation governing body of the American Board of Physical Medicine and Rehabilitation suggests [the injured person] has demonstrated evidence of functional improvement within to not justify additional [physical therapy] visits. At this point, it's noted that [the injured person] should be transition to a home exercise program, especially as there are no conditions documented that would preclude this.

The IRO reviewer further noted:

> Further therapy can be completed via a home exercise program. Therefore, physical therapy services rendered to [the injured person] on the [dates of service at issue] were overutilized in frequency and duration in accordance with medically accepted standards.

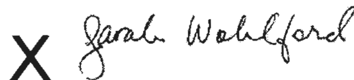
Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the physical therapy treatments provided to the injured person on June 16 and 18, 2021 were not medically necessary and were overutilized in frequency or duration in accordance with medically accepted standards, as defined by R 500.61(i).

IV. ORDER

The Director upholds the Respondent's determination dated July 14, 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