STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Level Eleven Grand Blanc
Petitioner **File No. 21-1564**

v

MemberSelect Insurance Company
Respondent

Issued and entered
this 12th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 5, 2021, Level Eleven Grand Blanc (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 MemberSelect Insurance Company (Respondent) that the 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 Respondent issued the Petitioner bill denials on August 5, 2021, and September 9 and 15, 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 November 1, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on November 1, 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 November 17, 2021. The Department issued a written notice of extension to both parties on December 15, 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 November 30, 2021.

II. Factual Background

This appeal concerns the denial of payment for physical therapy treatments rendered on June 6, 11, 22, 24, and 25 2021, and July 9, 15, 26, and 27, 2021. The Petitioner billed the treatments under procedure codes 97116, 97110, and 97530, which are described as gait training, therapeutic procedure, and therapeutic activities. In its *Explanation of Benefits* letter issued to the Petitioner, the Respondent denied payment on the basis that the treatments exceeded "the period of care for either utilization or relatedness."

With its appeal request, the Petitioner submitted documentation which identified the injured person's diagnoses as: other abnormalities of gait and mobility, diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration, sequela, and anoxic brain damage, following a November 2017 motor vehicle accident.

In a letter included in the appeal request, the Petitioner noted the injured person's deficits as requiring "assistance to perform wheelchair mobility due to visual impairments, variable physical, verbal assistance required for all [mobility-related activities of daily living], assistance for safe transfers, impaired balance, impaired coordination, impaired strength, decreased upper extremity functional mobility and decreased fine motor skills, impulsive behavior, visual deficits, impaired cognition, depression/anxiety, impaired communication/apraxia/dysarthria."

The Petitioner's request for an appeal stated:

> Due to the extent of [the injured person]'s injuries related to his [motor vehicle accident,] skilled physical therapy is necessary in some capacity throughout the remainder of [the injured person]'s life in order to prevent further complication and reduce risk of an increased number of comorbidities. Skilled physical therapy remains the most cost effective and safest option for [the injured person] at this time.

In its reply, the Respondent reaffirmed its initial determination that the physical therapy treatments were overutilized, and stated:

> Additional medical [documents] have been received and…were reviewed for the medical necessity of additional physical therapy visits, for date of injury 11/08/2017. Additional visits exceed [American College of Occupational and Environmental Medicine] and Official Disability Guidelines treatment guideline recommendations. Physical treatment therapy appears to be ongoing and, per history it appears over 580 sessions of therapy have been provided, with little to no interruption. Persistent ongoing symptoms reported, indicating the presence of, bilateral knee and back pain, were noted. The quantity of sessions completed to date exceeds the [American College of Occupational and Environmental Medicine] and Official Disability Guideline treatment recommendations with ample opportunity given to establish a home activity conditioning program.

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 involves a dispute regarding inappropriate treatment 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 treatment was overutilized in frequency or duration based on medically accepted standards.

The IRO reviewer is board-certified in physical medicine and rehabilitation. 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 MD Guidelines for Traumatic Brain Injury (TBI) and Official Disability Guidelines (ODG) for Head Physical and Occupational therapy for its recommendation.

The IRO reviewer noted that ODG recommend physical and occupational therapy 1-3 times per week for moderate to severe TBI patients, and up to 12 visits are appropriate for the treatment of hemiplegia in the subacute phase. Additionally, the IRO reviewer explained that a clinical plateau or failure to improve are indications for discontinuation of physical therapy.

Based on submitted documentation, the IRO reviewer further noted that the injured person had received 565 sessions of physical therapy as of July 6, 2021, with 184 of the visits being post hemiplegia. The IRO reviewer opined that the physical therapy treatments would be considered excessive in frequency or duration. Specifically, the IRO reviewer opined:

> The injured person had an anoxic injury which portends a less favorable prognosis than traumatic brain injury without anoxia due to the level of cognitive deficits. The physical therapy is provided when there is a potential for further improvement. It is not used for maintenance therapy. The records did not include documentation that the injured person had a potential for further improvement and that the treatment was not maintenance therapy.

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 6, 11, 22, 24, and 25 2021, and July 9, 15, 26, and 27, 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 determinations dated August 5, 2021, and September 9, and 15, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

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:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford