

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 102976-001

v

Time Insurance Company
Respondent

Issued and entered
this 30th day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 6, 2009, XXXXX ("Petitioner"), filed a request for an external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On February 18, 2009, after a preliminary review of the material submitted, the Commissioner accepted the case for external review.

The Commissioner notified Time Insurance Company (Time) of the external review and requested the information used in making its adverse determination.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization which completed its review and sent its recommendation to the Commissioner on March 3, 2009.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a fully-insured individual policy with Time. She received chiropractic care from July 2, 2008, through September 4, 2008. Time denied

coverage for the services. The Petitioner appealed the denial through Time's internal grievance process. After reviewing the claim, Time upheld its denial and issued a final adverse determination dated December 30, 2008.

III ISSUE

Was Time correct in denying coverage for the Petitioner's chiropractic visits?

IV ANALYSIS

In its final adverse determination, Respondent explained its decision to deny coverage:

Treatment began on or before April 17, 2008 for complaints of lower back, right hip and headache pain. A brief clinical evaluation was performed and treatment began. [Petitioner] was treated 30 times through September 4, 2008. No reevaluations were documented. Daily notes are brief and do not include detailed subjective or clinical information. No subjective complaints were documented after July 2, 2008. Treatment from July 2, 2008 through September 4, 2008 was not medically necessary.

The Petitioner's policy defines "medically necessary" as:

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Since this case involved a medical issue it was assigned to an IRO to determine if the

chiropractic care provided from July 2, 2008, through September 4, 2008, was medically necessary.

The IRO reviewer is a licensed chiropractor who has been in practice for more than 10 years.

The IRO reviewer's report includes these findings:

[T]reatment notes document that [Petitioner's] neck condition had flared-up and was treated at her 7/2/08 visit. [A]t [Petitioner's] return visit on 7/17/08, her neck pain had improved as she reported no new chief complaint related to this area. . . . [T]hese two visits were appropriate to address the flare-up in her neck pain. However, the documentation in subsequent treatment records does not substantiate the need for ongoing chiropractic care. . . . [T]he treatment records do not document ongoing symptoms and the response of these symptoms to the care rendered. . . . [T]here was no documentation of updated examination findings and an updated treatment plan based upon those findings.

The IRO reviewer concluded that Petitioner's chiropractic care for the period July 2 through July 17, 2008, was medically necessary. The care received from July 18 through September 4, 2008, was not medically necessary. The IRO's recommendation is based on extensive expertise and professional judgment and the Commissioner finds no reason to reject it.

V ORDER

The Commissioner upholds in part and reverses in part Time Insurance Company's final adverse determination of December 30, 2008. Time is required to provide coverage for the Petitioner's chiropractic care for the period July 2 through July 17, 2008. Time is not required to provide coverage for the services received from July 18 through September 4, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.