

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**

**Petitioner**

**v**

**File No. 119711-001**

**Humana Insurance Company**

**Respondent**

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**Issued and entered**  
**this 15<sup>th</sup> day of August 2011**  
**by R. Kevin Clinton**  
**Commissioner**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On February 24, 2011, a request for external review was filed with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*, on behalf of XXXXX (Petitioner).

The Petitioner receives health benefits under a certificate of insurance issued by Humana Insurance Company. The Commissioner notified Humana of the external review and requested the information it used to make its adverse determination. The information was provided on February 28, 2011. On March 2, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The case involves an issue of medical necessity so the Commissioner assigned the matter to an independent medical review organization which submitted its analysis and recommendation to the Commissioner on March 16, 2011.

**II. FACTUAL BACKGROUND**

The Petitioner sought treatment for neck and jaw pain. Her physician requested authorization from Humana for physical therapy. Humana authorized nine physical therapy sessions for the period of December 7, 2010, through January 21, 2011. The Petitioner's therapist provided three additional physical therapy visits (January 26, January 28, and February

3, 2011) and requested approval for an additional four visits. Humana denied coverage for all visits beyond January 21, 2011, after concluding that further treatment was not medically necessary.

Petitioner appealed the denial through Humana's internal grievance process. Humana did not alter its decision and issued its final adverse determination February 8, 2011.

### III. ISSUE

Did Humana correctly deny authorization for the additional physical therapy visits after January 21, 2011?

### IV. ANALYSIS

#### Petitioner's Argument

In a letter to Humana dated January 27, 2011, Petitioner's therapist stated that additional therapy was medically necessary based on an assessment performed January 21, 2011, which showed significant improvement in the Petitioner's symptoms and functional status, but also revealed continued cervical deficits warranting further physical therapy.

#### Respondent's Argument

In denying coverage, Humana cited several provisions of the certificate including the following provision which appears on page 46:

#### **Other limitations and exclusions**

\* \* \*

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

- Treatments, services, supplies or surgeries that are not *medically necessary*, except for the specified routine *preventive services* as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this *certificate*.

The certificate provides this definition of medical necessity:

***Medically necessary*** means the required extent of health care service, treatment or product that a *health care practitioner* would provide to his or her patient for the purpose of diagnosing, palliating or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service, treatment or product must be:

- In accordance with nationally recognized standards of medical practice and identified as safe, widely used and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;
- Not primarily for the convenience of the patient, physician or other health care provider;
- Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
- Performed in the most cost effective setting required by the patient's condition; and
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of service.

Humana states it denied the request for additional therapy because its medical necessity guidelines were not met, according to an outside medical review Humana requested. In its final adverse determination, Humana wrote:

[T]he independent Reviewer has determined that coverage for additional physical therapy sessions was denied correctly by [Petitioner's] plan. . . . [T]he reviewer states:

The patient in this case presented with neck pain and jaw pain with a diagnosis of cervicalgia. She was treated with PT from 12/7/10 through 1/21/11. She has made significant progress with decreased pain and increase range of motion in the jaw and neck muscles. The PT assessment done on 1/21/11 reported cervical range of motion as follows - 60% flexion and side-bending, 50% extension, and 75-90% lateral rotation. Jaw range of motion is reported to be within functional limits, paraspinal muscle strength is 4/5, and pain level is 1.3/10. The OrthoNet criteria for cervical spine pain states that discharge from PT is indicated when cervical flexion, side bending, and extension are 36 degrees, rotation is 48 degrees, muscle strength is at least 4/5 and pain level is 2/10- the patient meets all of these criteria based on the 1/21/11 PT progress report. As such, continuation of PT is not medically necessary at this time based on the OrthoNet criteria.

#### Commissioner's Review

Humana provides coverage for physical therapy services only when they are medically necessary. The question of whether additional physical therapy was medically necessary was presented to an independent medical review organization (IRO) for analysis as required by

section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is a physician in active practice who is certified by the National Board of Osteopathic Medical Examiners and the American Board of Physical Medicine and Rehabilitation. The IRO reviewer's report includes the following comments and conclusion:

The standard of care in terms of physical therapy (PT) is to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT once the patient has made significant objective functional gains.

It appears that the enrollee made significant objective functional gains, had a decrease in pain and an increase in range of motion with the initial nine (9) therapy visits approved and completed. The enrollee should have been transitioned to a home exercise program to continue functional gains in terms of [activities of daily living] and pain relief.

It is not clear from the documentation submitted for review what were the short and long term goals of therapy after the initial evaluation was done December 7, 2010. Furthermore, it is not clear if the patient met or did not meet the short and long term goals after the initial evaluation. Further clarification is needed in regards to why the enrollee was not transitioned to a home exercise program, as objective functional improvement is clearly documented.

[Citations omitted.]

. . . The enrollee has shown progress and, in this case, additional visits being requested exceed the recommended guidelines without any noteworthy exceptional factors. Transitioning the patient to a home exercise program would have been more appropriate sooner instead of after the completion of 9 therapy visits completed.

It is the recommendation of this reviewer that the denial of coverage issued by Humana Insurance Company for continued physical therapy services be upheld.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded some deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive expertise and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case.

The Commissioner finds that Humana's denial of coverage for the additional physical therapy visits is consistent with the terms of the Certificate of coverage.

**V. ORDER**

The Commissioner upholds Humana Insurance Company's adverse determination of February 8, 2011. Humana is not required to provide coverage for physical therapy visits beyond January 21, 2011.

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 60 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.

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R. Kevin Clinton  
Commissioner