STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Metro Management Services
Petitioner **File No. 21-1578**

v

State Farm Mutual Automobile Insurance Company
Respondent

Issued and entered
this 4th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 6, 2021, Metro Management 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 State Farm Mutual Automobile 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 a bill denial on August 24, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the date of service at issue.

The Department accepted the request for an appeal on October 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 October 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 November 4, 2021. The Department issued a written notice of extension to both parties on December 2, 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 December 28, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the denial of payment for pain management treatments rendered on August 2, 2021. The Petitioner billed the treatments under procedure codes 99214, 80305, and 99072, which are described as an office or other outpatient visit; drug test(s); and supplies and materials over and above those usually included with the office visit, respectively. In its *Explanation of Review* letter issued to the Petitioner, the Respondent denied payment on the basis that treatment was "not reasonable and necessary for the injured person's case, recovery, or rehabilitation as outlined in MCL 500.3107."

With its appeal request, the Petitioner submitted documentation which identified the injured person's diagnoses as: cervicalgia; chronic pain due to trauma; headache; low back pain; pain in left and right shoulder, pain in left and right knee, and pain in the thoracic spine following a January 2020 motor vehicle accident. In a treatment note for the date of service at issue, the injured person presented for a follow up office visit related to post motor vehicle accident management. The Petitioner noted the injured person's reported neck pain as a 7 out of 10 on a ten-point pain scale, and rated mid back, lower back, bilateral shoulder and knee pain as an 8 out of 10. The Petitioner indicated the injured person was ordered to receive physical therapy evaluation and treatment 3 times per week for 4 weeks. Additionally, the treatment note noted that the injured person's urine drug screening was sent to a laboratory and returned with a negative result.

In its reply, the Respondent reaffirmed its initial determination that the pain management treatments were not medically necessary. The Respondent included an independent medical examination report dated February 2, 2021 which noted that a referral for pain management was not indicated for the injured person based on clinical documents.

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.

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 date of service at issue based on medically accepted standards.

The IRO reviewer is a physician board certified in pain medicine. 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 clinical practice guidelines from the Ontario Protocol for Traffic Injury Management (OPTIMa) collaboration for its recommendation.

The IRO reviewer explained that care for common traffic injures such as whiplash-associated disorders, anxiety, and mild traumatic brain injury should include advice, education, and reassurance. Based on submitted documentation, the IRO reviewer noted that the injured person had received prior physical therapy (PT), interventional procedures, electroencephalogram (EEG), magnetic resonance imaging (MRI), X-rays, and medications. Specifically, the IRO reviewer opined:

> In this case, it was appropriate for the [injured person] to seek care and feel symptoms stemming from the accident some of which fall under [whiplash-associated disorders]. Nonetheless, this [injured person] had her accident on January 14, 2020. Her motor vehicle was "totaled," however, the car did not spin or roll over. In addition, the car did not have air bags deploy suggesting the gravity of impact was not as severe. The [injured person] had an evaluation in the emergency room. In addition, the [injured person] had multiple MRIs performed on cervical spine, lumbar spine, shoulder, foot, and knee. In addition, [the injured person] had an EEG even though no loss of consciousness was documented. It is noted the [the injured person] received multiple interventional procedures from February 3, 2020 to August 15, 2020. In addition, the [the injured person] has attended numerous sessions of PT since the accident.

The IRO reviewer further opined that the services rendered on August 2, 2021 were excessive, and considered repetitive based on prior treatments noted in the submitted documentation.

Based on the above, the IRO reviewer recommended that the Director uphold the Respondent's determination that the treatments provided to the injured person on August 2, 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 determination dated August 24, 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