STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Hesselberg Chiropractic
Petitioner **File No. 21-1026**

v

Citizens Insurance Company of the Midwest
Respondent

Issued and entered
this 18th day of June 2021
by Sarah Wohlford
Special Deputy Director

ORDER

I. Procedural Background

On April 28, 2021, Hesselberg Chiropractic (Petitioner) filed with the Director of the Department of Insurance and Financial Services (Department) a request for appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for appeal concerns bills denied by Citizens Insurance Company of the Midwest (Respondent) for chiropractic treatments.

The Department accepted the request for appeal on April 28, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on May 3, 2021, and the Respondent received a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on May 25, 2021.

The Department assigned an independent review organization (IRO) to review the issues in this appeal and provide a report and recommendation to the Department. The IRO submitted its report to the Department on June 14, 2021.

The Petitioner's appeal is made under R 500.65, which allows a provider to appeal to the Department from a determination made by an insurer. The Petitioner seeks reimbursement in the full amount it billed for the treatments and dates of service at issue.

II. Factual Background

This appeal concerns the denial of bills by the Respondent to the Petitioner for chiropractic services rendered on April 5 and April 7, 2021. The Respondent issued a determination dated April 26,

2021. The Respondent did not request a written explanation from the Petitioner regarding the medical necessity or indication for the treatment rendered to the injured person relevant to this appeal.

With its appeal request, the Petitioner submitted supporting documentation demonstrating the following diagnoses for the dates of service at issue: segmental and somatic dysfunctions of the lumbar, thoracic, cervical, sacral, and pelvic regions; low back pain; thoracic spine pain; cervicalgia; and disorder of ligament, unspecified site. The treatments included spinal manipulation, mechanical traction, and therapeutic exercises. The CPT codes billed were 98942, 97012, and 97110, respectively.

In determination letters issued April 26, 2021 for both dates of service at issue, the Respondent denied payment for CPT codes 98942, 97012, and 97110. In its reply to the appeal, the Respondent issued a response dated May 18, 2021, reaffirming their denial that the services rendered were not medically necessary.

Petitioner's Argument:

In its appeal, the Petitioner argues that the care provided to the injured person was medically necessary for treatment of low back pain, upper back pain, and cervical pain.

Respondent's Argument:

In its reply to the appeal, the Respondent explained that it denied the billed services as not medically necessary after reviewing the medical documentation provided by Petitioner.

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 of services.

In support of its position, the Petitioner argues that the injured person had slowly been improving since treatment began December 28, 2020. In the medical record, the Petitioner noted that the injured person's pain level had decreased from 6/10 to 4/10 on the pain scale and that the injured person was expected to reach maximum medical improvement by the end of the treatment plan. No initial examination or subsequent re-examination records were included with the supporting documentation.

The Respondent's initial determination dated April 26, 2021 stated that the medical services were reviewed based on the documentation submitted and in accordance with national and regional standards of care. The determination referenced the following standards of care in support of its conclusion:

> Patients with low back or neck pain resulting from a motor vehicle accident should show statistically significant improvements in pain level, function and medication use. (Schofferman J., Wasserman S.). The current evidence suggests that exercise alone or in combination with education is effective for preventing low back pain. (Daniel Steffens, PhD 1,2; Chris G. Maher, PhD1; Leani S. M. Pereira, PhD2; et al.)

In its initial determination, the Respondent also stated that the short-term goal lacked a durational element, and that the Petitioner's documentation did not substantiate the treatment rendered as in accordance with generally accepted medically standards.

The Director assigned an IRO to review the case file. In its June 14, 2021 report, the IRO reviewer concluded that, based on the submitted documentation, medical necessity was not supported on the dates of service at issue, the treatment was overutilized in frequency or duration, and the short-term goals documented in the records did not meet medically accepted standards.

The IRO reviewer is board-certified in chiropractic medicine. The IRO reviewer referenced R 500.61(i), in its report, 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, boards, and associations. The IRO reviewer relied on the Official Disability Guidelines (ODG) for medically accepted standards relating to treatment of the injured person's diagnosed conditions.

The IRO reviewer summarized its recommendation as follows:

> The chiropractic treatments provided to the injured person on 4/5/21 and 4/7/21 were not medically necessary in accordance with medically accepted standards as defined by R 500.61(i) and were overutilized in frequency or duration compared with such medically necessary standards, and the short term goals documented in the 4/5/21 and 4/7/21 medical records do not meet such standards.

The IRO reviewer stated that "in order for additional treatment to be considered appropriate, there must be documented functional improvement." According to the medical record, the injured person's baseline pain levels were 4-6/10 on the pain scale. The medical record for the dates of service at issue noted that the status of pain complaints in the neck, upper back, and low back remained unchanged with moderate pain levels at 4-6 on the pain scale. When comparing the injured person's pain levels at baseline and during the dates of service at issue, the IRO reviewer opined that "there was no documentation of quantifiable functional improvement."

Specifically, the IRO report noted the following:

> The chiropractor consultant indicated that in the absence of functional improvement, additional treatment is not supported by medically accepted standards. The expert consultant indicated that there was no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to the guidelines.

According to the IRO reviewer, the submitted medical documentation regarding work capacity showed that the injured person had achieved maximum medical improvement compared with baseline levels. The IRO reviewer stated that the medical records for both dates of service at issue noted that the injured person could perform 50% of their usual work and these findings remained unchanged from baseline.

The IRO reviewer recommended that the chiropractic treatments provided to the injured person on April 5 and 7, 2021 were not medically necessary, in accordance with medically accepted standards, as defined by R 500.61(i), and were overutilized in frequency or duration compared with such standards. The IRO reviewer also recommended that the short-term goals documented in the records did not meet medically accepted standards. Therefore, the Director upholds the Respondent's determination dated April 26, 2021.

IV. ORDER

The Director upholds the Respondent's determination dated April 26, 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:

6/18/2021

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford